S. HRG. 98-938

LONG-TERM CARE: A LOOK AT HOME AND COMMUNITY-BASED SERVICES

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-EIGHT CONGRESS

SECOND SESSION

GRANITE CITY, IL

APRIL 13, 1984

Printed for the Use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE

36-095 O WASHINGTON : 1984

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, DC 20402

3141-15

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LONG-TERM CARE: A LOOK AT HOME AND COMMUNITY-BASED SERVICES

FRIDAY, APRIL 13, 1984

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Granite City, IL.

The committee met, pursuant to notice, at 9:30 a.m., at the Granite City Center, Belleville Area College, Granite City, IL, Hon. Charles H. Percy, presiding.

Present: Senator Percy.

Also present: Marcia Pape, legislative assistant to Senator Percy; and David Schulke, professional staff member.

OPENING STATEMENT BY SENATOR CHARLES H. PERCY, PRESIDING

Senator PERCY. I am really very delighted to see so many of you here this morning. You will not believe it, but I demonstrated it to you at 11 o'clock last night and again at 5:30 this morning. I was thinking of every one of you. At 11 o'clock last night, we were on the Senate floor dealing with the deficit reduction bill. When you have a bill like that, it becomes a Christmas tree bill; everyone can hang their own ornament.

In fact, Senator Dixon and I had a few of our own on there for Illinois. Just one of them provided summer jobs for 16,000 young people. That bill was an important bill, and Senator Howard Baker announced that we had facing us 62 more amendments at 11 o'clock in the evening.

That meant he figured if you just take an hour for each one, you would have to work that night, all day today, and all day Saturday. The temptation was there to call and just cancel this meeting and get word to as many of you as possible. However, we realized it would be impossible to get word to you because it was an open meeting. The papers had gone to press and the radio, maybe you wouldn't be listening to the radio.

So I said to our Senate majority leader, Howard Baker, let's see if we can't finish today. And at 4 a.m., I left Washington, and we kept our 16,000 jobs there, and a lot of other projects for Illinois. I went home, took a quick shower and went right out to the airport and didn't bother doing anything else. Mrs. Percy will bring all of my baggage at the recess later today.

But I am delighted to be with you and I am more glad than ever. As I said, we were tempted at 11 o'clock to cancel the hearing, but this is an extraordinarily important hearing, and it's an official hearing of the U.S. Senate Special Committee on Aging.

I have been on that committee for 13 years now, I guess. I have been on the committee longer than any other Democrat or Republican. I am the senior ranking member of the committee, and the older I grow and every year that goes by, the more interested I get in that committee. It was the only committee of Congress on the aging, but the House, under Claude Pepper, has also adopted the same format and is using a similar committee.

It's this committee that faced up to the problems of Social Security: Was it going to go bankrupt. We really worked on that, and let me report to you the solvency of the Social Security system is something that should never worry anyone in this room or any of their children. Under the guidance of this Senate Special Committee on Aging, we have a sound, solvent system to provide your Social Security checks to you every single month.

But another concern and problem that has been voiced to me through the years by senior citizens, the most common of those problems, is the wish to remain active and independent in their communities.

I am absolutely committed to helping maintain the elderly, the infirm, and those classified as terminally ill in their own home, in their own homes, for as long as possible, through the intervention of timely health, social, and supportive services.

I have just gone through this with my own mother who fell a few months ago. My mother was 92 last year. Some of you know Mother. She's a beautiful concert violinist. She's played the violin for 86 years, and is taking lessons every Sunday. The teacher now comes to her home, but she gets out and gives concerts.

She gave a beautiful concert just 4 months ago, but she has now fallen and is confined to her home. They said she should go to the hospital, but she wants to maintain her own home. I'll be back traveling tonight to be with her tomorrow and to work out her problems, seeing that she has a chance to maintain her own home, and not go into a home where she would have nice care but wouldn't be surrounded with the atmosphere where her friends and neighbors could drop in and see her, and she would feel she was in charge of her own little domain.

So I have gone through that.

Home care reinforces and supplements the care provided by family members and friends, and it encourages maximum independence of both thought and functioning.

Long-term care has traditionally been interpreted as those services provided on a long-term basis to chronically ill or impaired persons in institutions.

As a result, long-term care was commonly viewed as being solely delivered by the medical profession. However, the excessive cost of institutional care and the increased demand by older persons and their families for community-based services have contributed to a growing awareness of community-based alternatives.

I wonder, because I didn't see it but I heard about it, how many of you happened to see the news last night with NBC doing the photographing of the hearing that I held on doctors who had not paid back their grants. They had received these grants on the condition that they would practice for several years in an area that is short of doctors.

How many of you saw that program? How many of you who did see it felt that that doctor should have been forced by us to pay his debt to the Federal Government?

It looks like every hand has gone up. You can tell your friends and neighbors about that program, and the shock that I had when I realized that $61 million was owed by doctors that had committed when they got their free education from the Government. It cost you, as taxpayers, up to $86,000, and when they got out they refused to practice in those physician shortage areas. And they should be fined—fine them three times as much as their cost—so it would be $250,000 in fine they would have to pay, plus interest. It just adds to the cost of medical care when you have people like that, that I call medical deadbeats, who walk out and welch on an agreement— a solemn agreement—that they made with their Government. We're going to try to stamp out those things as rapidly as we possibly can.

We're going to use the term "long-term care" a great many times. The phrase "long-term care," as we use it today, encompasses a wide array of services offered in a variety of settings ranging from nursing homes and other institutions to adult daycare centers and other innovative noninstitutional arrangements to the patient's own home.

Community-based long-term care typically refers to such noninstitutional services as home health care, including part-time skilled nursing care and other medically related services. It refers to occupational, physical and speech therapy, social services, including adult day care, counseling, financial advice, transportation, and friendly visiting. It refers to nutritional and health education, homemaker, chore and personal services, including cooking, shopping housekeeping, home maintenance and feeding

Actual services vary depending on what the patient's particular needs are. Meals-on-Wheels is another program I started. I delivered Meals-on-Wheels many days, and got a great deal of enjoyment out of doing one of those programs. We thought it would help people stay in their home, rather than being taken out of their home.

Chronic conditions limit in varying degrees the elderly's ability to carry out the basic activities of their daily living, such as eating, bathing, and dressing. My mother, for instance, just can't bathe herself or step into the tub by herself. She needs help with this. Once she's in there, she can bathe her arms and so forth but she can't bathe her back anymore, so she needs a little help there. But after taking care of other people for 92 years, it's about time some of us started taking care of her.

For example, one person with arthritis may become homebound while another suffers from only occasional flareups, so the condition differs. When compared to other age groups in the population, a significantly higher proportion of persons 65 and older are limited in activity due to a chronic condition. However, functional limitations in daily living increase more dramatically for the group over 75 years old. Over 50 percent of this age group face serious limitations with 22 percent so severly limited in activity that they cannot carry on independently.

In other words, about one out of four persons age 75 and older are unable to take care of themselves and are totally dependent on other assistance and help. Thus, a broad range of health and social services is needed for that person. The proportion of elderly persons needing help in personal care or home management assistance increases dramatically in the upper age ranges, while only 6.7 percent of persons in the 65 to 74 age range need the help of another person. This figure more than doubles to 15.7 percent for persons in the 65 to 85 year age group, and surges to 39.3 percent in the 85 and older age group.

Just think of that, even in the age group 85 and older, 60 percent don't need the help of other people. I like to put a positive emphasis on that. That's a wonderful figure, and probably not very well known in this country. So, let me state again, of those 85 and older in this country, 60 percent are able to take care of themselves without the help of another person. Only slightly less than 40 percent need the assistance of other people, but that's still a lot of Americans.

By the same token, 34.8 percent of this age group need help in one or more basic activities and about a third need help in walking and going outside the home.

Let me just stop for a moment to tell you that last July 1, I was cutting across the lawn from the Dirksen Senate Office Building to the floor of the Senate to cast a vote. I was cutting across there because I had a few extra minutes and it was lovely outside, warm but lovely, and a television crew stopped me. I said, "Oh, I don't have time for television now, unless you're from Illinois." They said they were cable news, but they held up a book, I'll just hold this up, a book, and it was entitled "Growing Old in the Country of the Young," by Senator Charles H. Percy.

So I wondered what, in the middle of this field, they were doing holding up a book I published about 10 years ago. They said they just wanted to ask me one question for television. I said all right. And I got on television and they said, Senator Percy, if you were writing this book today, would you change the title, "Growing Old in the Country of the Young"?

I said, no, I don't think so at all. The whole purpose of the book was to show that we have all kinds of money to spend on young people. We overbuild college dormitories; we've got thousands of them empty. We have people 70 years old on the waiting list for senior citizens' housing. If you're 80 years old and told you have to wait 7 more years, that's not very helpful.

I said, why do you ask that question? They said the Census Bureau reported today that no longer are we a country of the young. Today, whereas for over 200 years we've always had more people 21 and under than 65 and older, today the Census Bureau stated we have changed now. We have more people 65 and older than 21 and under. I'll be eligible to enter that austere group of senior citizens on September 27, this year, and I'll probably become a part of the majority then. At least we ought to have enough clout to do things together.

Severe effects of chronic illness may prevent individuals from functioning independently and have an impact on the need for future health and long-term care and services.

In 1980, 10.8 million people over the age of 65 had some degree of limitation in daily activity ranging from mild to severe, due to chronic illness. Future estimates demonstrate that 14.5 million persons age 65 or older are expected to have functional limitation at the turn of the century. This figure will reach 23.3 million by the year 2020, and 31.8 million by 2050. So we're increasingly becoming a people who have more and more older people living. But, obviously, the longer they live, the more dependent they then become on other people.

These projections demonstrate that because of the growth of the population with functional and daily activity limitation, twice as many health and long-term care services as are presently available will be needed by the year 2020. Nursing home care is extremely costly, and is not always appropriate. Discounting inflation, between 1965 and 1985, the cost of nursing home care will have quadrupled. Institutional care costs up to $15,000 a year for private pay patients and $13,000 per year for medicaid patients. At least one-third of these private payers spend down and become eligible for medicaid in less than one year after admission to nursing homes. This is why in recent years, health care has grown from 5 percent of our total gross national product, all the sum total of goods and services produced in the United States. It has doubled to where it now is 10 percent of our gross national product. State governments are finding payment for their share of long-term costs an increasing burden. Because the nursing home population is growing, and the cost of providing nursing home care is increasing, Medicaid costs are consuming a greater proportion of limited State budgets. It is time to look for other less costly and more appropriate ways to provide long-term care.

The sources for funding for these long-term services are varied. Home health care has become one of the fastest growing components of the medicare and medicaid budgets. Legislative changes in 1981 allowed for State waivers in medicaid and limited waivers in medicare. Illinois has been the recipient of one of the medicaid waivers, and used it to establish the community care program which Dr. Jean Rogers will discuss later this morning.

Home care, including homemaker, chore, and home health aid services, is one of the major service categories under title III of the Older Americans Act. This act also authorizes a home-delivered meals program, which I worked to establish many years ago and mentioned earlier this morning.

The Federal Government supports a variety of other programs which provide some assistance, but very few of these programs have the broad goal of sustaining the impaired individual within the community.

As a result, there is an array of programs and services that are very difficult to coordinate and integrate at the local level due to differing eligibility criteria, target populations, and administrative networks.

I am going to skip a few of these items so we can get on with our witnesses. Yesterday, however, the Senate approved an amendment similar to one I cosponsored, known as the Home Care Protection Act, to solve the problem in the definition of the term intermittent care, which Mary Lou Turcol will be discussing later.

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It would define intermittent care to include one or more visits per day on a daily basis by a nurse or home health aide for up to 45 days, and thereafter under exceptional circumstances. This very important legislation would ensure that those persons who are most in need of skilled home health care are not denied those benefits. Yesterday, on the bill we were working on, the supplemental appropriation bill, here again was the chance for the chairman of the Special Committee on Aging, Senator Heinz, and me, to discuss something that will benefit people for a long time to come—people that need home health care protection.

This hearing will focus on home and community-based care. I look forward to hearing from the wonderful group of witnesses we have here today on these issues, and their recommendations for overcoming the current limitations in home health care.

I wonder, at this time, if Frances Hargiss and Orville Prott, our first witnesses, could come up to the platform, please.

I would like to take this opportunity to extend my thanks to Dr. Frank Gorman, provost of Granite City Center for Belleville Area College, for providing us with this facility for holding today's Aging Committee hearing.

We also have with us today Roosevelt Peabody, executive director of the Southwestern Illinois Area Agency on Aging; and Helen Cain, president of the Illinois Council of Home Health Services. I would like to thank them as well for all they help they have provided in seeing you have this hearing.

This is an official U.S. Senate hearing, so it is not possible to have give and take from the floor. This will be conducted under the rules of the Senate, just as any hearing is conducted in Washington, but I didn't want to hold it in Washington. Too many of you could not have come down there, and for that reason I wanted to hold it right here. The rules are the same.

Let's begin with Ms. Hargiss. Ms. Hargiss, I wonder if you would please tell us about your experience with home health care.

STATEMENT OF FRANCES HARGISS, COTTAGE HILLS, IL

Ms. HARGISS. I am blind and have quite a few ailments, including heart trouble and diabetes and high blood pressure, and my nurse has been coming about 4 years now, and she's wonderful. She's from the Visiting Nurses and she comes once a week to fill my needles and to check me. Then she tries to get me to have the homemakers come but I was afraid, I was afraid of getting somebody in that smoked or drank or something, and, you know, that maybe they would leave something that would smoulder and then catch fire, and finally I had to go to the hospital and Dr. Taylor told me that I had to get somebody or, you know, I would have to go to a nursing home. I had worked for 60 years, and I had finally gotten my home, and I didn't want to give it up. So I finally got this home care. I don't regret it a bit.

JoAnne is a wonderful worker, she's just wonderful, she comes 4 days a week and works for me, does the things that I need done, and well, she takes me anyplace I need to go and she's just wonderful. And I thank God everyday for the Visiting Nurses, and that

homemaker I've got now, and I just don't know how to thank everybody that's made this possible, because I do need the help.

And I want to thank you, Senator Percy, for seeing about this for us old people that need the help, and like I said, I've worked all my life until about 6 years ago when I became blind and, of course, I haven't been able to work since.

So I worked all my life. I worked 38 years at Beverly Farm with the retarded, sick, and helpless people, and I worked up until the day I went to the hospital for my operation. I came out, well, I couldn't go back, and like I said, I thank God for my friend here, she's so wonderful, and a nurse I have every week come out from the nurses, she's wonderful, too. All those nurses are wonderful, from Kay too, on her days off, she comes and they're wonderful, too. But of course, I call her my Kay because she's been with me for so long, and she's so wonderful. She's not only patient, but she takes my blood pressure, she checks me all over, and she fills my needles for the week and she talks to me and she's just wonderful.

And I'd like to say I thank God every night I go to bed that I have got such wonderful people to help me, and again, I thank you, Senator Percy, for seeing and pushing this thing through for us old people. We need it.

Senator PERCY. First, I'd like to ask if all of you would join in extending a deep appreciation to a very, very wonderful person, JoAnne Cole, who is Ms. Hargiss' homemaker.

Second, I want you to know that, Ms. Hargiss, that your entire statement will be incorporated in the record. But I think the words you have just spoken right from your heart are even more eloquent than your written statement.

I would like to read a letter to me from Dr. Norman E. Taylor with reference to the hearing, and I want to make this a matter of record, regarding Frances Hargiss.

DEAR SENATOR PERCY: Miss Hargiss has been a patient under my care for the last 10 years. This poor, unfortunate, lady has had multiple problems over the years, including diabetes, blindness, severe cardiac decompensation at times, marked lower extremity edema and marked problems with anxiety, depression, associated basically with her blindness. However, despite all of this, this lady continues to be cared for at home in her own house environment despite the fact that she finds it very difficult to do so because of her lack of vision. This care has been provided at home basically with the help of her family, but in addition to this she adds a community Visiting Nurses Association, and they have helped her manage her diabetes at home by providing her insulin and visiting her at home and monitored her closely, with her problems of hypertension, diabetes and heart disease.

Through use of the home health care programs in the community, Ms. Hargiss has probably avoided 10 years in the nursing home and I think the expense connected with the home health care program probably is certainly justified in relation to what it would cost in the nursing home.

Continued support of the home health care services for people like Ms. Hargiss is fairly essential in order to make sure that the older population gets adequate medical care at a cost that can be afforded by the taxpayers. I think continued support of this type of program is certainly indicated and has the full support of the medical profession.

Sincerely,

NORMAN E. TAYLOR, M.D., S.C.

I think continued support of this type of program is certainly indicated, that she has the full support of the medical profession.

I ask you in light of what you just heard, does this service have the full support of the Granite City community? [Applause.]

Thank you.

Ms. Hargiss, let me be very personal to you because you have brought back recollections to me. When I was 8, 9, and 10 years old I had a piano teacher by the name of Mrs. Barrett who used to come once a week for a dollar. I would get piano lessons and it lasted 45 minutes to an hour. She was totally blind and had been blind since birth. By the time I reached age 12 I was perhaps then confident enough to ask the question that burned in my mind all those years, and I finally blurted out, "Mrs. Barrett, isn't it just terrible to be blind?"

"Oh," she said, "Chuck, there's lots worse things in life."

And I said, what?

And she said, "Well, for instance, all my friends that are deaf." She said, "You know, I have never seen anything but comfort, happiness, and joy expressed toward me, but my friends that are hard of hearing constantly have people annoy them, asking why don't you hear me."

They never ask a blind person why didn't you see me, but a person hard of hearing, they get impatient. Every time my wife gets impatient with me and says, don't you have your hearing aid on, I say, don't forget Mrs. Barrett. Say that in a nice kindly way, not an impatient way.

And another thing, those without sight, they have just an intuitive insight about some things. We hired many blind people to work at Bell & Howell Co., We have a lot of darkrooms and they can perform work in the darkrooms better than anyone else could. It inspired me some years back to start going to the Recording for the Blind and to the Atlee School of the Blind, a few miles from my home, in Georgetown, in Washington, DC. I have recorded DeToqueville's "Democracy in America." I recorded it for a young blind student working for a Ph.D. She has gotten her Ph.D. since then, but she needed to read the DeToqueville, and the whole time I read that book I never had a greater thrill, knowing how I would be opening for her one of the great dramas, as seen by a young prince coming to this country in 1882. And you have privileged us by coming here today, and I am really very, very grateful to you.

I'd like now to introduce Orville Prott, who will be able to give us a little insight that may be somewhat different.

This panel, of course is made up of people who have been recipients of health care.

Orville Prott, please tell us your story.

STATEMENT OF ORVILLE PROTT, EDWARDSVILLE, IL

Mr. PROTT. My name is Orville Prott, and I am here to represent my daughter, Jean.

She's 45 years old and she's had multiple sclerosis for 28 years. Now she's paralyzed from the shoulders down and for the first 10 years she was able to take care of herself pretty well, but for the last 20 years she went first to a wheelchair and then bedfast, and now she's—the wife and I have to take care of her continuously.

However, my wife recently developed heart touble and she needs assistance herself. Now, Jean's doctor told us that we could get help from home health care under medicare so we contacted our

Family Services and Visiting Nurses Association and they sent her someone, 1 day a week, for about 2 hours to bathe. Then there was a registered nurse coming in. She comes in about once every 2 weeks and checks her vital signs and Jean's catherized, and changes her catheter, and this was a big item for us, that catheter. Now, once a week isn't very much to be bathed. She has to be bathed everyday, in addition, and Jean needs help constantly. She has to be fed. Somebody has to be there for her in case of an emergency, somebody who's to be in the house with her at all times.

I operate a trucking line, and I work 3 or 4 hours a day in the office. In order to do this I've had to hire a girl to bathe Jean the other 4 days, and on the weekend my daughter-in-law comes in and bathes her, and the other times my wife and I take care of her at night. We pay this out of our own pocket. This runs about $600 a month.

We also rent an electric bed and an air pump, and wheelchair and that was rented, comes through medicare, and we have to pay 20 percent of that, too, out of our own pocket. Now we get some of this back from medicare, but most of the rest Blue Cross-Blue Shield and health coverage is $112 every 3 months. Jean pays that out of her disability.

Now, she's been at Barnes 42 different times and since she's had MS and her hospital bill is around $80 to $100 over what the insurance company pays, and we have to pay for that.

Now, Jean receives $396 a month in Social Security disability. It doesn't go very far because her drugs, she pays for her drugs, her medical insurance and some of the extras, you know, and, however, her income doesn't come close to meeting her costs. As long as my health is good, I am willing to hang onto the truck line because without the extra money I receive from working it would be pretty tough to meet these expenses.

Jean's care runs about $900 a month, not including any hospital costs. Now, my whole family contributes to Jean's care. I have two other daughters and a son. They all volunteer to help and one of them comes in every evening to help get Jean up in the wheelchair. They also come over on weekends and stay with her in case I have to take the wife to the doctor or something like that.

Now, if anything happens to me either the rest of the family would have to take care of her or she would have to go into a nursing home, and she doesn't want to do that, that's for sure.

So, without the home health service, there would be no alternative.

Now, in closing I'd like to say I'm a pretty old man. I'm 75 years old, and I may live 1 year or 10 years; without the help of Family Services and Visiting Nurses Association, I don't know what I'd do.

Thank you.

Senator PERCY. Mr. Prott, may I just correct you on one situation, two situations.

You said you are an old man and you are not. You are a young man of long standing, and you look in great shape to me. When you put a limitation of 1 to 10 years, I'd start at 17 years. That's where my mother is, and mother still is up and down those stairs quite a bit and she's pretty active. She's still playing the violin, so you've got a lot of years ahead of you.

You have had to go out on your own to find someone to come in and help supplement the health care, home health care, your daughter receives in order to have her maintained as semi-independent in the community.

How difficult was it for you to find someone to provide these services for Jean?

Mr. PROTT. Well, it was difficult but we was lucky. We ran into a girl who is 36 years old. She had some nursing. She worked as a nurse in a nursing home, and we got Mary to come in 7 hours a day now, and stay with her and bathes her and writes letters and everything for 4 days a week, and of course it costs me but it's worth it.

Senator PERCY. Sure, but looking at the other side of that cost, I have checked prices in the area, and nursing home care would average over $1,200 per month. It would cost your family a great deal more if she had to have that kind of care.

Who would pay for it if you were unable to? It seems to me she would become a medicaid patient in no time at all and the State would have to be picking up the tab if you couldn't maintain her in your home; is that right?

Mr. PROTT. That's correct.

Senator PERCY. That's correct, and now just a question to Frances Hargiss.

I want to put this letter from your physician in the record. You are very lucky because you do have a fine family physician and home care providers are looking after you.

If, for some reason, you were not able to receive these services, what do you think would actually happen.

Ms. HARGISS. Well, I would have to go to the nursing home because that's what my doctor told me, if I didn't get this help, I would have to go to the nursing home.

Senator PERCY. Well, while that would be an alternative that wouldn't be a desirable alternative, and we try to prevent that as long as we can.

Let's give our wonderful people here a hand. [Applause.]

Now, we'll ask our second panel to come forward, the panel consisting of Mary Lou Turcol, Helen Cain, Jane Rimbey, Jeanne Tippitt, and Roosevelt Peabody.

This next panel is made up of various home and community-based services.

We have today Mary Lou Turcol, the home health care administrator at Staunton Hospital; Helen Cain of Alton, who who is president of Illinois Council of Home Health Services; Jane Rimbey from the Visiting Nurses Association of Morgan and Scott Counties; Jeanne Tippett, Community Care Systems, Inc.; and Roosevelt Peabody, the executive director of the Southwestern Illinois Area Agency on Aging.

And I believe we will start out with Helen Cain.

Helen, if you pull that right up to you, that would be fine.

STATEMENT OF HELEN L. CAIN, ALTON, IL, PRESIDENT, ILLINOIS COUNCIL OF HOME HEALTH SERVICES

Ms. CAIN. I'm Helen Cain, president of the Illinois Council of Home Health Services.

This organization represents 90 percent of all of the licensed home health services in Illinois. I am also a program administrator of home health services at the Family Services and Visiting Nurses Association of Alton, IL.

On behalf of the council, my colleagues, and participants, we thank you and the Committee on Aging for affording us in southern Illinois the opportunity to address the subject, noninstitutional, long-term, care. We all appreciate your concern and that of the other committee members in bringing needed services to the aged, sick, and infirm in Illinois and in the Nation. These services enrich their lives and enable them to remain in their homes and community with dignity and pride. And we thank you for that.

As the Illinois Council representative, I wish to address two concerns, the medicare waiver of liability provision. There are three concerns to this issue.

We, the council, do not support elimination of the waiver of liability provision. We do believe that the permissible rate of error should be minimally changed back to 5 percent from the present 2.5 percent. This provision protects the providers who, acting in good faith, could not have known that services furnished to certain individuals would not be compensated.

In order for an agency to be compensated, its overall denial of claims rate must be less than 2.5 percent of medicare services given. If an agency exceeds this limit, no reimbursement is received. A home health agency must use diligence in determining eligibility.

Under the current HCFA guidelines, section 256, HIM-II, a home health agency has no right to appeal a claim denial when it is paid under waiver. The rationale is that since the agency was paid it has no liability and is not at risk and therefore shouldn't have the right to appeal. The denial is immediately charged to the waiver before administrative review or reconsideration procedure has taken place. Agencies are adversely affected by the last of the appeal right. HCFA should not be allowed to create a prohibition against the right to appeal by using a guideline. There is no statutory or regulatory basis for the HCFA guideline. There is harm to the agency when it cannot appeal. When the claim is denied and immediately applied to the waiver, they affect the agency's waiver level and can push them over the 2.5-percent level. This, then, results in loss of waiver eligibility for PIP and increased administrative burden, all of which can have significant impact on cash flow particularly for small agencies. Small agencies are usually the providers of care in southern Illinois and rural America.

The fiscal intermediaries currently are taking home health agencies off the waiver when they have made errors in honoring claims which should have been disallowed, but they will not retroactively restore a home health agency's waiver status where the fiscal intermediary, or an administrative law judge, has reversed the claim

denials which force the home health agency to lose its waiver in the beginning.

Intermediaries should be required to retroactively restore the home health agency's waiver status where the intermediary's denial decision caused the agency to lose its waiver. The intermediaries should not be allowed to retroactively take an agency off waiver until the balancing right of retroactive restoration of waiver is in place.

There is nothing in the law, regulations, or even guidelines which either allows a fiscal intermediary to retroactively remove a home health agency from waiver or prohibit the intermediary from retroactively restoring an agency to waiver. We ask for equity.

The second issue which I would like to address is the amount of paper that flows to the intermediary to process a billing on one client for 1 month. You have before you an example that consists of 40 pages. This inflates the cost of visits as this one billing costs $1.39 on postage, plus staff time to compile, duplicate, and assemble for mailing. Where therapies are involved, some paper could be cut if the therapist did a monthly summary—we then would not have to send a copy of each visit. In many agencies the therapist is under contract. In some agencies, the time to complete the summary is an additional expense. To bill other third-party papers, even public aid amount of paper, involves only two to four sheets at the most, to do the billing. In Missouri, home health agencies as recently as 6 months ago only had to submit two to four pages as well. The fiscal intermediaries, again, are not consistent with their demands for billing and documentation to review claims. Again, inequity across the Nation which also provides HCFA a wide variance across the Nation in the cost per visit. It is things like this that increase the cost in some areas.

HCFA has circulated to the fiscal intermediaries a new HCFA intermediary manual, HCFA publication 13.3, issuance, which will impose new data element requirements on home health agencies in submitting claims to medicare. The draft issuance requested by the Office of Management and Budget [OMB] is under review by OMB and fiscal intermediaries. According to HCFA policy, no provider will have opportunity to comment on the issuance until it is issued in final form to intermediaries. The finalized form was to be issued to intermediaries the first quarter of 1984. Some intermediaries have already been using the draft form. There is substantial change in policy in this proposed issuance and it is not being issued pursuant to the Administrative Procedures Act [APA]. The new forms which will be used to implement the proposed revision had not been cleared by OMB pursuant to the Reduction of Paperwork Act of 1980. There has been no analysis of impact on small businesses pursuant to the Regulatory Flexibility Act of 1980, and Executive Order No. 12291.

The proposed issuance as we understand it demands more documentation, more paper, and manpower on the part of the home health agency, which is a small business.

We ask you, Senator, and the Special Committee on Aging, to explore this issue with HCFA and OMB in terms of uniformity in reporting and volume of paper required.

In closing, I would like to remove my hat as an Illinois Council of Home Health Services representative, and put on my hat as program administrator for Family Services and Visiting Nurses Association of Alton, IL, because that brings me close to the people that are here. Our agency is the designated care coordination unit, CCU, by the Illinois Department on Aging [DOA], for the northern one-half of Madison County and Bond County. The agency fully supports the concept of this program which is supported by the Department on Aging, through the medicaid waiver and the Southwestern Illinois Area Agency on Aging, through title III.

Through the efforts of CCU with hospitals, hospital patients who may have previously been transferred directly to nursing homes have been assessed and when appropriate, directed into community care program services, which include homemaking, chore housekeeping, and/or daycare, thus returning to their homes and communities with these supportive services.

There remains another large segment of the senior population which needs home health services in order to remain at home. This group is not qualified for public aid and/or medicare because of both program guidelines. As a CCU we support research and pilot projects which would demonstrate the need and how to respond to that need and maintain the individual at home.

And I thank you, Senator.

Senator PERCY. Thank you very much, indeed.

We will now ask Jane Rimbey, director, Visiting Nurses Association of Morgan and Scott Counties, to testify next. I wonder if I could point out to you the convenience that is being offered to us, that is often done to me on television programs, notifying you how much time you have left.

We are going to have to stay quite rigidly on the 5-minute limitation because we most be adjourned by 12 noon. We certainly would not want to forego the last half.

STATEMENT OF JANE RIMBEY, JACKSONVILLE, IL, DIRECTOR, VISITING NURSES ASSOCIATION OF MORGAN AND SCOTT COUNTIES

Ms. RIMBEY. Thank you, Senator Percy. Thank you on behalf of our agency for allowing us to testify here today and also on behalf of all the people in the State of Illinois that agencies such as ours serve. The proliferation of home health agencies throughout the Nation is of grave concern to those agencies who have been dedicated to providing the highest quality health care in the most cost-effective manner. Each time another agency opens its doors to provide a service in a community where service is in existence, costs immediately escalate. The funds necessary to establish a new agency should be channeled into an existing agency for effective cost containment.

Efforts should be made very soon to curtail the escalating number of new agencies being established where quality care is currently being provided by an existing agency. Concern over the dwindling medicare funds should address the fact that much of these funds are being used for establishment in organization of new

agencies—rather than support of agencies with a long history of service.

How can the Government continue to allow this proliferation without realizing that this is what is eating away at the already dwindling medicare funds.

A possible solution would be to no longer license and certify new agencies if the existing agency is meeting the needs of the community and providing quality care.

Competition is fine but only if quality of care is not overlooked. When Federal dollars are utilized there should be mechanism built in to assure that quality care and reasonable cost are both examined thoroughly.

To control the outbreak of new agencies the Federal Government should take a look at the existing standards and licensing requirements for all home care programs to insure that quality care is provided.

Currently, agencies providing homemaker and chore/housekeeping services which are federally funded are not required to meet certification and/or licensure nor are there training requirements for persons working as homemakers or chore/housekeepers. At the present time if an individual with or without a background in health care wishes to become a provider of home care, the only requirement necessary is the desire to do so.

I am going to stray a little from my prepared text and say that this past week I spent a great deal of my time taking away from my administrative responsibilities in dealing with a situation where an implement dealer and his son have entered into the home care business. These people have no experience, no health care background, but are going into a home health care business. Some new agencies are only providing care as long as there is a source of payment. As soon as the financial resources are depleted these same agencies dump the patients on the not-for-profit agencies. An agency should be required to continue to provide the needed services when sources of funding for care are depleted.

Model home health systems have been established and are running well, however, as opportunists study them and attempt to provide a semblance of care, the patients served are put at risk.

How is quality to be maintained if licensure is not required of everyone providing health care services to individuals in their homes? We promote licensure and/or certification for all home care programs utilizing Federal dollars.

When quality takes over for quality and profitability becomes the name of the game—who loses—the patient and the health care system. We must not allow profitability to get in the way of quality.

Thank you for this opportunity.

Senator PERCY. Now we'll have Mary Lou Turcol.

STATEMENT OF MARY LOU TURCOL, ADMINISTRATOR, HOME HEALTH CARE DEPARTMENT, COMMUNITY MEMORIAL HOSPITAL, STAUNTON, IL

Ms. TURCOL. I'm Mary Lou Turcol from a small hospital, Macoupin County Hospital in Staunton, IL, and I'm administrator of home health care department.

My topic here is very dear to us and I must say that at 4:30 this morning it was announced the intermittent care issue was passed. The revision, the clarification, and the definition of the intermittent care at the medical level were very pleased. The intermittent care term is used in home health to describe the medicare coverage for participants.

And I'm going to quote exactly from the Medicare Home Health Care magazine, the definition of intermittent care is to meet the requirement for intermittent skilled nursing care an individual must have a medically predictable recurring need for skilled nursing services. In most instances this definition will be met if the patient requires a skilled nursing service at least once every 60 days. The issue addressed in this testimony is one of intermittent versus daily or more frequent as opoosed to 24-hour care. The problem is with the definition of intermittant care, the guidelines have permitted more than one visit to the same patient on the same day depending on unusual circumstances where the patient's prognosis indicates the medical need.

But the information collected from a number of States indicates that various restrictive interpretations of the term intermittent are being imposed by some intermediaries, and an intermediary is someone you can say that we report to to make sure that our care is justified.

In some instances it has been used to bar more than one visit to an individual a day regardless of the justification. In other instances clients who are in need of and who receive services 5 or even 3 days a week are being deemed as in need of daily care and therefore not compensable.

There are even reports that such determinations made in the present based on restrictive interpretations are being applied retroactively resulting in retroactive denials. The definition of what constitutes intermittent care vary tremendously depending on the fiscal intermediaries' interpretation. As a result what is supposed to be a national program is not in force uniformly and what is covered for one beneficiary in one State is not covered in another State.

I wish now to cite briefly one specific case from our home health department that explains the problem more clearly. Mrs. A.B. was admitted for home nursing following hospitalization for severe back and hip pain due to cancer metastases. Hospital treatment included symptom control which was intramuscular medication for pain at 4- to 6-hour intervals. The treatment was to be continued at home, but this would mean that the frequency of visits would be at least once a day or more. We were very hesitant about providing this care due to the fact that the reimbursement laws were such so we called Chicago, which is where our intermediary is based, and from them I produced this statement.

This type of care would only be covered for 5 days. After this time, if the patient is still in need of skilled continued care at this level, he/she should be hospitalized for re-evaluation.

The point of this case is the fact that the home health department could not meet the patient's plans of care due to reimbursement regulation. The frequency of services, not the availability of services, required a complete change of plan. The physician's order were changed and oral medication was initiated. This plan was not pretested prior to discharge but the patient was sent home. In effect, the following events occurred. The client's physical and mental status deteriorated at home. The psychological effects of her disease in conjunction with the ineffectiveness of the oral medication precipitated rehospitalization following only 5 days in the home. She was again placed on IM medication as originally ordered and had to be placed in a nursing home for followup care.

Is not the purpose of home health care to followup hospital care and in turn to prevent and postpone expensive institutionalization? Is the intermittent clause being defined correctly? Is it too restrictive and is it consistent throughout the State? I believe this is the issue. Services in the home health departments have been developed to satisfy medicare requirements for participation and not the needs of the home health care patient as shown specifically in this case.

Much to our appreciation this morning by passing Senate bill 2338 which Senator Percy cosponsored, we'll now begin to see changes. We strongly support his efforts to make intermittent care definition more congruent with congressional intent and other regulation. Just reflecting back a little bit before I heard this morning's announcement, we feel that legislative advocacy for home health service is week for several reasons. The primary constituents are old and without energy or ability to demand legislative action. Congressional committees on aging lack the authority to send a bill directly to the floor and must wait for broader acceptance of the issues before action can be taken.

This is changing. The Government feels that inhome services are more risky than hospitalization and institutional care. The irony of this is that hospitals are discharging more clients who are in need of intensive nursing, physical therapy and other services, into the hands of home health care agencies, who are being told that they cannot care for them because they need more than intermittent care.

With the hospital protective payment plan, DRG's, now in effect, the problem is likely to increase with patients being released from hospitals more quickly and in a sicker condition. The further irony is that the Government policy is pushing many clients into institutional settings when they prefer to stay in homes with resulting increased cost to the Government.

In conclusion, specific recommendations would require major changes in current eligibility criteria as follows:

Replace the skilled care criterion with reimbursement for those services required to prevent or substitute for institutionalization, including provisions for medically directed nursing care such as medications, complex dressings or treatments. These are to be supplied when required for an existing condition.

Two, professional nursing intervention such as teaching, counseling and health maintenance be provided for the patient and/or family as deemed necessary.

Three, abolish homebound status and substitute two other eligibility criteria, A, that a need for home adaptation for required care be demonstrated; B, that functional status and living arrangement be the basis for determining eligibility for additional services.

In conclusion, for a more personal standpoint, cost effectiveness of medical care that increases the life and productivity of the elderly is a cost that must be weighed against all potential health care benefits. It is an ethical as well as an economic question, and one that must be asked and answered in making of health policies. The answer does not simply rest on economic productivity or on health versus social cause or on family versus government responsibility, but it does involve all three issues. Policy intent and policy outcome should be compatible.

Thank you.

Senator PERCY. Thank you.

I might say that, though I stated that this would be conducted in accordance with the rules of the Senate, applause is not permitted in the hearings in Washington. That's the big difference between a hearing in Washington and Granite City: I can make my own rules out here.

Now, we're very happy to have Jeanne Tippett, who I believe all of you know is senior vice president of Community Care Systems, Inc.

Jeanne.

STATEMENT OF D. JEANNE TIPPETT, SENIOR VICE PRESIDENT, COMMUNITY CARE SYSTEMS, INC., EAST ST. LOUIS, IL

Ms. Tippett. I, too, Senator, am happy to be able to speak to this group of people, and we thank you for giving us this opportunity.

I am Jeanne Tippett, senior vice president of Community Care Systems, Inc. We're a proprietary agency that is funded by the Department of Aging to provide in-home care services consisting of chore housekeeping and/or homemaker services to those seniors that are in jeopardy of going into an institution, and when we service one such as Ms. Hargiss, we know why all the hard work has been done by the Senator and by the Department of Aging, and by those of you that are interested in the care of a senior citizen.

We also are funded by the southwestern Illinois area agency on aging under title III-B contract, to provide some additional chore housekeeping services to seniors in Bond and Randolph Counties.

We are very pleased to be involved in both areas. A major concern of ours, however, is providing the inhome care to a number of clients that might be falling through the cracks. Those clients with income or assets slightly above eligibility guidelines and to those that do qualify but are not able to extract from their budget that which is needed to be within the program. Information from 1980 census and DOA show that of the 1.8 million people over age 65 in Illinois, only 15,000 are currently being served by the program. We believe that 15,000 is but a small percentage of those in need. A small percent of those who so desperately struggle to maintain

their dignity and independence by staying in their own homes. Such a fine, worthwhile program, so many in need, and yet so few are being served.

Could it be that we need to take a closer look at the eligibility guidelines? What is the common denominator that most affects the income of the elderly? Is it not medical costs? Is any consideration being given in the program eligibility guidelines for medical costs?

I'll just give you a brief overlay of the physiological changes in aging:

Folds of the brain flatten resulting in decreased circulation of blood within the brain.

Some air sac membranes in the lungs are replaced by fibrous tissue—interferring with the exchange of gases within the lungs.

The stomach secretes less acid and fewer enzymes that aid digestion—that's written by our nurse, not by me.

Although these changes occur in varying degrees, they contribute to the decrease in general good health and increase in chronic illness. Rising medical costs have a major impact on all age groups but they impact even more greatly on the fixed income of the elderly. The elderly spend an average of $2,000 annually of medical costs. That makes a big difference in the amount of their available income.

And if I could, I'd like to give you a quick example. There's a husband and wife who just recently had been interviewed to see if they could qualify for the community care program. They, in fact, did. The gentleman had worked all of his life and had received an infuse of chemicals while working in his position, and he later suffered a stroke. All of the funds for this injury exhausted his insurance benefits. His wife now has inoperative brain cancer. They do receive a substantial income from Social Security and his pension, and they were made eligible for the community care program, but they could not afford to take from their budget the $88 per month that they would need to be on the program. And this is because of their huge hospital bills for their illnesses. They pay approximately $180 per month in medicine alone, and they still owe hospitals, a radiologist, anesthesiologists, and many other miscellaneous medical bills. The husband said, "If I never receive another medical bill, I still could not afford the services because it will take me 27 years to pay what I owe now."

Because of this, we feel that some consideration must be given for medical costs when determining eligibility for the program. We feel that this minor change could have a major impact. Although Community Care Systems, Inc., is a proprietary agency, we believe in the quality of care, not the quantity of dollars.

Mr. Vala founded this agency based on concern for the total person, not just their wallet. His philosophy of accountability and responsibility to the elderly has prompted our concern for the number of unserved clients. We feel that we would not be meeting that responsibility if we did not, once again, urge you to alter the eligibility requirements to give consideration for medical costs.

Thank you.

Senator PERCY. I was particularly anxious to have a proprietary agency testify. We have looked to the proprietary agencies many times over as a guideline of efficiency and to be a yardstick for

public sector areas, hospitals, and health care that we don't have any measuring stick for.

Sometimes, when a proprietary operates actually in the black, they're operating at lower costs than public facilities. For that reason, we are indebted to Frank Vala, president; Michelle Cook, director of medical services; and Jeanne Tippett, senior vice president.

We're delighted to have had that testimony. And now, Roosevelt Peabody.

STATEMENT OF ROOSEVELT J. PEABODY, EAST ST. LOUIS, IL, EXECUTIVE DIRECTOR, SOUTHWESTERN ILLINOIS AREA AGENCY ON AGING

Mr. PEABODY. Thank you, Senator Percy.

My name is Roosevelt Peabody, and I'm the executive director of the Southwestern Illinois Area Agency on Aging. This organization was formed in 1974, as a designated focal point for providing planning and service for seniors in the counties of Bond, Clinton, Madison, Monroe, Randolph, St. Clair, and Washington.

I, not being familiar with the rules of the hearing, Senator, I was wondering if it would be all right if I would ask my board members and advisory council members who are present, to stand. Is that in order, sir?

OK, if all members of the board and directors and advisory council of SWIAAOA would stand for one moment.

OK. On behalf of the board of directors and advisory council of our agency, I would like to thank you for holding the hearing here in our area.

Senator PERCY. Stand up just again, will you. [Applause.]

We are going to break every rule in the book.

Mr. PEABODY. Briefly, Senator, the main thrust of our agency's effort is to achieve the major goals of the Older Americans Act. In regard to today's hearing, that relates to: one, securing maximum freedom with dignity in a home environment for those capable of self-care with appropriate services; two, provide a network of supportive services for all seniors; and, three, prevent premature and unnecessary institutionalization.

For the sake of time, we'll not go through our slides which our smiling assistant, Lou Waters, has set up because the signs do come rather quickly, but we believe we are addressing these goals in a positive manner.

In regard to preventing unnecessary institutionalization, we believe the State of Illinois is in the forefront nationally of this effort.

The region 8 aging network, both formal and informal, is in step with this effort. This is evidenced by the fact that statewide in Illinois 16 percent of individuals prescreened were diverted from institutional care. In region 8, 48 percent of the individuals prescreened were diverted from institutional care which represents three times the statewide average for diversions from long-term care facilities.

In terms of specifics, SWIAAOA has established a network of 14 information and referral offices to do just what the name says, provide information and referral to appropriate agencies for service. We also maintain a toll free number for the State of Illinois and

that number is 1-800-642-3859, which is to assure that all persons are provided an opportunity to avail themselves of our services. Our monthly newsletter, the Senior Times, is distributed to thousands of seniors, agencies, and appropriate officials, within and without the State of Illinois.

Other persons testifying here today will address in detail the needs of seniors, but basically we are speaking of a subgroup of frail or dependent elderly, in most cases 75 years of age or more, female, and living alone, who have an accumulation of health, social, economic, and environmental problems. These problems serve to restrict or impede their independent living. Other descriptive phrases which are which are used to categorize their status are depressed, confused, isolated, and in some instances, abused or neglected.

We work closely with the 68 long-term care facilities in our area through our ombudsman and Nursing Home Visitors Volunteer Program. I call your attention to the map on my left which locates and identifies those facilities by level of care provided. This map is used daily by our staff in assisting hospital discharge planners and seniors in securing placement convenient to their home environment and family. All information and referral offices are provied with an updated version of the Illinois Department of Public Health Directory of Long-Term Care Facilities in our area.

I see by my sign that my time is up, but in closing I would like to state the SWIAAOA supports the concept of in-home care. We hope the Congress of the United States will continue to provide moneys to maintain and/or expand this program as determined by the needs of our older Americans.

Thank you.

Senator PERCY. Thank you, Mr. Peabody. Your full prepared statement will be inserted into the record at this point.

[The prepared statement of Mr. Peabody follows:]

PREPARED STATEMENT OF ROOSEVELT J. PEABODY

Thank you Senator Percy and members of the Senate Special Committee on Aging. I am Roosevelt J. Peabody, executive director of the Southwestern Illinois Area Agency on Aging. SWIAAOA, which we are referred to in the area, was organized in 1974 as a not-for-profit agency. It was designated region 8 of the network of area agencies on aging in Illinois, by the Illinois Department on Aging.

Our service area is home for 104,469 seniors who reside in the counties of Bond, Clinton, Madison, Monroe, Randolph, St. Clair, and Washington.

On behalf of our board of directors, staff, and the entire aging network of region 8, I want to commend you for holding this very important hearing in our planning and service area.

Briefly, Senator, the main thrust of our agency's effort is to achieve the major goals of the Older Americans Act. In regard to todays hearing that relates to:

(1) Securing maximum freedom with dignity in a home environment for those capable of self care with appropriate services.

(2) Provide a network of supportive services for all seniors.

(3) Prevent premature and unnecessary institutionalization.

We believe we are addressing these goals in a positive manner. In regard to preventing unnecessary institutionalization we believe the State of Illinois is at the forefront nationally of this effort. The region 8 aging network, both formal and informal, is in step with this effort. This is evidenced by the fact that statewide in Illinois, 16 percent of individuals prescreened were diverted from institutional care. In region 8, 48 percent of the individuals prescreened were diverted from institutionalized care, which represents three times the statewide average for diversions from long-term care facilities.

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The accompanying illustration depicts the client intake referral system of SWIAAOA and the related aging network.

Briefly, starting at the top, we have a senior client who is in need of service. This need for service may be determined by the client, his or herself, or by one of the surrounding illustrated persons, agencies or officials. A contact is made with SWIAAOA via mail, telephone or visit.

A determination is made within SWIAAOA as to the appropriate staff involvement, including community care specialist, protective service officer, ombudsman, or in most instances, the information and referral specialist.

Then depending on the circumstances, a referral is made to one of our three case coordination units with assignment based on the address of the client. In some instances, a phone referral will suffice, but in those cases where requests for home delivered meals or community care program involvement is indicated, a home visit and assessment is made. Upon review of this assessment, the client may be referred to one of our title III-B, C1, or C2 service providers, or is assigned to one of the eight community care program vendors in region 8. In other instances the client is referred to other alternate services, both formal or informal which are available in the area.

Documentation and reporting of all referrals is made to SWIAAOA and then to IDOA, Springfield, under procedures established by IDOA.

In closing, let me state that SWIAAOA supports the concept of in-home care. We hope the Congress of the United States will continue to provide moneys to maintain and/or expand this program as determined by the needs of our older Americans.

Thank you.

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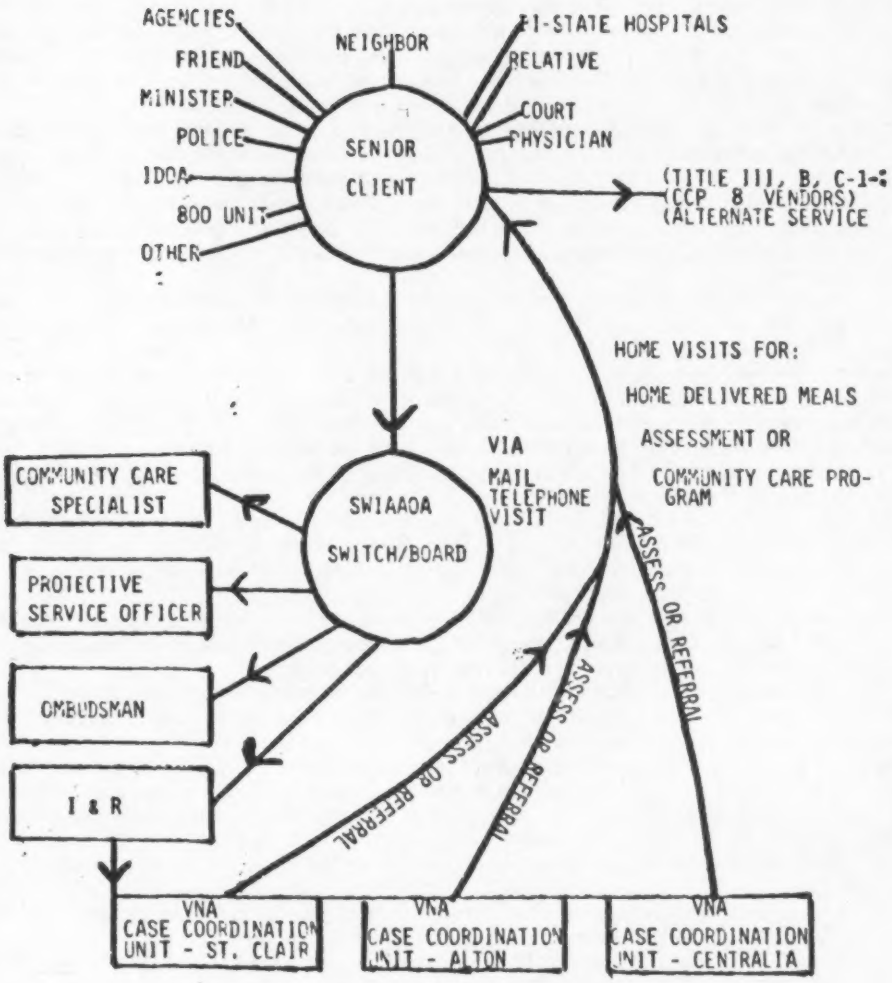

CLIENT INTAKE REFERRAL SYSTEM

BY

SOUTHWESTERN ILLINOIS AREA AGENCY ON AGING
8787 STATE STREET, SUITE 200
EAST ST. LOUIS, IL 62203

TOLL FREE NUMBER (ANY WHERE IN ILLINOIS) - 1/800/642-3859

Senator PERCY. Now, we'll meet the press.

How many in Illinois are affected by the current limitation on intermittent care? I am speaking of those receiving daily care or the three week program limitation on services.

Ms. TURCOL. I think if I can just reflect on our agency I would say about a third of the patients in our agency are affected by the intermittent care. But the problem is we find that daily visits even sometimes, even in the case of daily dressings, are not reimbursed. When this, in fact, does postpone institutionalism, prevent it, and allows the patient to be discharged earlier in the home.

The issue seems to be one of interpretation of what does intermittent care really mean. Does it mean daily? Does it mean two times a week? Does it mean more than once a day?

I think this is the problem.

Senator PERCY. Mary Lou, you are a hospital-based, home health care provider, although I understand that Staunton Hospital has not yet adopted the prospective payment system. Many hospitals in the State have.

What do you think the effects of this new system are on home health care here in Illinois?

Ms. TURCOL. We foresee a large influx of patients in the home health care department because of the restrictions on being hospitalized. The hospital stay will be much shorter. They will be discharged in a more acutely ill stage and as home health nurses or the home health care department, in fact, will be taking care of more sicker clientele, requiring really more services.

Senator PERCY. Well, then, in other words, you think that patients will be discharged earlier, needing more intensive home services?

Ms. TURCOL. Yes.

Senator PERCY. Will you be able to provide the care they need?

Ms. TURCOL. The provision of care is not the problem.

The question, the frequency of care, the skill we can provide. We are trained nurses. We can provide the same nurses in the home as they do in the hospital, and I think with your assistance and passing of the bill this morning, defining intermittent care as more than one visit per day, will surely help the problem.

Thank you.

Senator PERCY. Thank you very much.

And, Helen Cain, we need to look at the future, to recognize that we are going to have so many people here in Illinois, as well as in the Nation, needing more care.

What is being done to provide for the growth of this severely frail population?

Ms. CAIN. What is being done—I am sorry——

Senator PERCY. What is being done to provide for the growth when we're going to have so many more who are what we call in the frail population, that are going to need help if they are going to stay at home?

Ms. CAIN. In terms of speaking on behalf of the council within the council itself the growth of the home health services and agencies within the State, I think, are beginning to appear in anticipation of that. I think that when I say that 10 years ago there were about 60 home health agencies that were certified by the State of

Illinois, today we're leaning close to 200 with the waiting list of those agencies. I think within the height of those densely populated areas of the State that we have some of the problems with, more agencies than perhaps numbers of individuals to serve, I think in the southern part of the State in our rural areas, we have the greater concern of how the small agencies who are so jeopardized by reimbursement in all areas can grow to meet the need.

Senator PERCY. There's one other problem I'd like to present to you. We're extremely anxious to hold down the volume of paperwork which is horrendous in this whole field. We have also attempted to provide adequate protection for taxpayers' money that is being spent, against fraud and abuse. If enough of the paperwork is eliminated, what protection would you recommend that we have? If you can't answer that right now and you would like to think about it, I will keep the record open and you can give us a written reply.

Ms. CAIN. I very quickly can think of one area in which I think this could readily be assisted, and I think that is in terms of the process in which medicare certification takes place within agencies that once a year were evaluated in terms of meeting the law, the rules and regulations, and the quality of care that we provide. In the State of Illinois our own agency has not been recertified only just 1 week ago, and the waiting time exceeded the year.

I don't have trouble with the 2-year limit, but what our State suffers drastically from is the amount of dollars that fed through the medicare program sends to our State, to provide funds for those qualified certifiers, and I think that that's where the guarantee can come, if the State were provided dollars for those certifiers who could run herd, so to speak, on the quality of care and the reliance of the care.

Senator PERCY. Very good. I thank you very much.

Jane Rimbey, as you've mentioned, there is a concern that it's too easy to set up a home health agency.

What specific protections would you recommend to ensure that existing home health agencies—not just new ones—are well staffed and well equipped, as we want them to be?

Ms. RIMBEY. You might say that all of the agencies in the State of Illinois must be licensed. These are agencies that are providing home health services. Services which are considered home health service are skilled nursing, speech therapy, physical therapy, occupational therapy, and home health aide service. I think that I would recommend that all agencies providing the other two services that are considered part of home health care, homemaking, chore and housekeeping, would be licensed and certified. I don't know if licensure guarantees quality care, but I certainly think it helps. It does ensure that the staff and the agency are qualified, properly trained and educated, and I think that that has to help.

Senator PERCY. Thank you.

Almost everyone of us can readily see and understand how important it is to have quality nursing care. We know when we're not getting it, and we know when we are getting it, as our personal, distinguished witness was able to impart to us in such a meaningful way. But what kinds of problems occur when chore homemaker standards of quality are not assured, or enforced?

Ms. RIMBEY. Some of the problems that appear is that without proper supervision and training of the chore homemaker person, they might provide services which don't fall within the realm of their capabilities, thereby endangering the safety of the patient.

I feel that the chore homemaker program should have professional supervision. I think a professional registered nurse supervising, because the people they are caring for are ill, or disabled, and do have health problems which do need to be supervised by professional people. I think that if standards such as those were adopted and required of those types of agencies, then I think there would probably be a better guideline of quality.

Senator PERCY. Thank you very much, indeed.

Now, let's turn to Jeanne Tippett, and home care that is provided proprietarily.

Let me just say I go back when people say, oh, well, they'd rather have a nonprofit organization taking care of some of these things. I keep thinking that the steel mills are built all over the country, 84 countries have steel mills. I don't know any of them that can produce steel as cheaply as they are in Japan and England and Germany.

When I was working with the company—Bell & Howell—we grew from 1,300 to 13,000 employees while I was head of the company. If we were operated by the Government, we never would have grown over 1,300, and we probably would have had to end up costing twice as much money

That is not the way to do things. We can't do things as efficiently as in the private sector, but do have a yardstick to measure by. I am going to put a question to Jeanne Tippett.

Your agency is in business to make a profit. What are you doing to ensure that quality care is being provided to clients while keeping your costs down?

Do you have a real incentive for keeping costs down, not just letting this continue to skyrocket? Everytime they go up, they have to jack up the rates, and jack up the insurance costs, Blue Cross-Blue Shield, and you have medicare and medicaid to consider.

Ms. TIPPETT. I'd like to preface my statement by saying we're in the business of providing service to seniors. They're our only concern, and that's why we're there.

Without them we would not be in business at all. The philosophy of the Community Care Systems is based on quality of care for the senior. We set our own standards within our own agency so we can continue to provide services in an efficient and productive manner.

Senator PERCY. Can everyone hear in the back of the room? You have to take that microphone, Jeanne, and really work into it.

Ms. TIPPETT. So I was saying that Community Care Systems philosophy is based on the care to the senior. Seniors are why we're in the business. We want to provide and do provide quality care. We do set standards on ourselves; our administration staff is kept to a minimum. The staff that we have is all involved in the program. There is no one who is just there to take up space. Each person has a specific duty, and we train our in-home personnel to go into the client's home and be aware of their needs and provide the services needed in a quick and effective manner. We monitor that provider of service in the client's home. We talk to the client. We talk to the

worker. We talk to them together to verify the client is receiving the scheduled services. We work very closely with the case coordination unit so that if they do go in and find a problem all they have to do is let us know, and we'll go out and take care of it immediately.

I guess I can just basically say that, yes, there's a profit. However, there was not a profit in the very beginning. We all had to learn where our expertise was, thereby cutting cost and improving services to the senior. In our organization, we set standards of our own that we expect each employee of Community Care Systems to follow.

Senator PERCY. Very, very good. I understand that last July your corporation took over the homemakers' services previously being provided by the home care unit of Staunton Hospital. They could not compete with your rates. How are you able to do that?

Ms. TIPPETT. I'd like to answer that by saying we're a nonmedical type of service. Services that the health care agency was performing, that is, blood pressure, pulse, and injections are services that we could not provide under funding of the Illinois Department on Aging. The homemaker service that is listed by the Department on Aging does not include medical services. When you're a nonmedical type of service, you can bid less because we do not offer those kinds of medical services. When we took over the clients of the agency of Ms. Turcol, that agency was a great deal of help to insure the client an easy transition. I feel quite sure that those clients are receiving that same kind of quality medical care even though we are providing the basic in-home care services.

Senator PERCY. I would like to thank you very much, indeed. Now we will turn to Roosevelt Peabody.

We all appreciate having your comments on health care from a local perspective, as you have given it. You're out in the community. You're uniquely qualified because you're out in the community. You're uniquely able to identify with the needs of persons in this area.

How difficult is it to find services within the community?

Mr. PEABODY. Well, sir, I can answer that in one or two ways. One, it's not difficult for one at all to find the service, that is, if the person uses the avenues we have for them, that is, our toll-free number or one of the providers who have testified here. However, the problem is, when you find the service of coordinating your efforts and assuring that the service can be provided at costs the community can afford.

What we have found, it has been our experiences that were it not for our community care program in the State of Illinois, many of the seniors who had fallen in the cracks before by that method are being cared for now. That's why I would say it is easy to find the service of community care program is successful in the area, 8 as well as the other 13 area agencies. I believe the State of Illinois, in the State a person can readily find the service within our area in the State.

Senator PERCY. Are there enough home care services available in this area, or are some people's needs simply going unmet?

Mr. PEABODY. Yes, we have enough service providers in our area as has been evidenced here. We have now proprietary services

which are providing competitiveness, that the natural process had not experienced in the past and the coordination has gotten out of the way. We find the coordination has opened up many of the doors for the services to be made available. The thing to do now is to approve our networking to assure that all of these service employers have a funnel to speak with the senior using any of the multipurpose centers or providers in our area.

They can go in there and be assessed directly into the level of care that they need so in a shorter answer to your question, yes, we have the service providers and with the natural process as well as proprietaries, we are now able to address those needs of our seniors.

Senator PERCY. In your testimony, Mr. Peabody, you mentioned the nursing home ombudsman program. Many people here may not be too familiar with that program. Can you tell us how the ombudsman program helps people get the appropriate services in the community.

Mr. PEABODY. Well, it's a very simple process that we have. The nursing home ombudsman is initiated through the Illinois Department of Aging and Funding. They are made available to us. What we do is coordinate our services with those of volunteers and other agencies in the seven-county area, that is, to see people are going to the nursing homes and visiting with seniors.

They're acting as advocates on behalf of seniors and they act as advocates on behalf of those families who are anticipating the need for that service. Subsequently,what our staff does is act as a more or less liaison between not only the family which might wish to have certain information on nursing homes, but for the client who's in the nursing home, and keep and maintain some communication with people and friends. One of the most, I guess, devastating things a senior may undergo is the separation from their loved ones and friends.

Usually persons going into nursing homes have no one left in the community. The nursing home program, the visiting program we have lets that person know they are not forgotten.

It gives them an opportunity to keep some contact with people outside, so to speak, so people who are interested in helping and would like to help us in this regard contact the agency. We maintain a direct line with the nursing home and administrators as well as those who are operating the institutions to insure that the client in that home is not forgotten.

So our program is very successful in that regard because it really makes a person feel as though they continue to be worth something to somebody.

Senator PERCY. Thank you very much, indeed.

This has been a fine program. Let me put you right on the spot here and ask you to vote by a show of hands on two issues.

Put this question to yourselves.

Are there any eligible requests your respective agencies cannot serve because you don't have the money to hire the necessary staff to provide the service?

If your answer is yes, there are many people that you cannot serve because you don't have the money, please raise your hand.

If your answer is no, that you are providing adequate services and you have enough money to provide those services, raise your hand.

We don't allow Senators to not vote.

Mr. PEABODY. Again, I would like to say that we are providing the service. However, we do need more funds, because I think there's a trend now, that we are witnessing. We are trying to take the limited funds that we have. We are now going into contracts with proprietaries and competitive bidding, but in that same process of efficiency, we find that there are many areas that you need more money to address, so the more proficient you become, I think the more funds are needed to maintain that level of proficiency and to expand your level of operation.

So my answer is yes, we could do quite a bit more with more money.

Senator PERCY. Anyone else?

Jane, if you care to expand.

Ms. TIPPETT. Yes, I'd like to say that in our agency we do provide the needed services we get to anybody who has the need. We don't turn anybody away because we don't have the dollars. If they can't be met, the copayment, we have some dollars we use directly in that direction. I am not saying we have all the money in the world, and we can provide all the service people need, but we hope we are meeting the needs of people in the community we serve.

Thank you.

Senator PERCY. Thank you very much.

Let me ask one more question, and I'll ask you to take a choice of three choices: the question, how are your clients being affected by new medicare prospective payment system known as DRG's?

Now, I'll give you the choice. First, there's no effect upon them whatsoever. Second, there's an effect and it's negative. Third, there's an effect on them, and it's positive.

Now, those of you who feel there's no real effect on your clients, raise your hands.

Those of you who feel there's an effect and the effect is a negative one, raise your hands.

One, two, three, four, five. That means that no one is left to have a positive effect. It must be a plus or minus effect, because no one says positive effect.

Ms. TIPPETT. I'd like to answer that. In our agency we're receiving increased numbers of referrals directly from the hospital because of DRG's. We are seeing in some situation they are handled very nicely with daily care, intermittent thing. We do have some patients, however, that are being sent home too soon and are going back to the hospital with 24 hours time spent, and the problem with the intermittent care probably we'll be able to do a much better. It's both ways.

Senator PERCY. Very good.

Let's give our panel a big hand.

Senator PERCY. Today, on our third panel we have Phyllis Pinkerton who is the president of the Illinois Association of Area Agencies on Aging, and Dr. Jean Rogers, who's the division manager of the Community Care Program, Illinois Department on Aging

in Springfield. We'll now ask if Phyllis Pinkerton will be good enough to go right ahead and speak with us today.

STATEMENT OF PHYLLIS H. PINKERTON, BLOOMINGTON, IL, EXECUTIVE DIRECTOR, EAST CENTRAL ILLINOIS AREA AGENCY ON AGING, INC., AND PRESIDENT, ILLINOIS ASSOCIATION OF AREA AGENCIES ON AGING

Ms. PINKERTON. Thank you, Senator.

Again, welcome to Illinois. We're delighted to have you home. We appreciate the opportunity to address this Committee.

I'm Phyllis Pinkerton, director of the East Central Illinois Area Agency on Aging in Bloomington, and president of the Illinois Association of Area Agencies on Aging, a nonprofit organization representing the board, advisory councils, and staff of the 13 area agencies in Illinois.

Thank you for this opportunity to address the issue of home and community based services for older Americans. The need for home and community-based care for our growing aged population and the current imbalance in our health care system toward acute and institutional health care have been documented through many national studies and illustrated through other testimony presented here today.

My comments will focus on the role of area agencies on aging in developing a continuum of care at the local level and in assisting older persons in obtaining needed care.

In a report issued in 1983 entitled "Restructuring Medicaid: An Agenda for Change," the national study group on State medicaid strategies identified the following issues concerning the reform of the long-term care system in this country.

First, defining the extent of public responsibility for meeting the need for long-term care.

Second, building on and enhancing family and informal care arrangements.

Third, defining the need for long-term care and the relationship between need and eligibility.

Fourth, altering the balance away from acute medical and institutional care.

Fifth, promoting housing, nutrition and personal care services.

Sixth, promoting alternative living arrangements.

Seventh, training case managers and providers of community-based long-term care services.

Area agencies on aging in Illinois in partnership with the Department on Aging and local providers of social, health and nutrition services are currently addressing these issues in several ways:

First, through planning activities, area agencies on aging are working with aging organizations, service providers and local units of Government to assess the needs of the older population; maintain an inventory of available services and assess the degree to which they meet the needs of older persons; and assist communities in reaching a consensus about their responsibility for providing services, setting priorities and goals, and researching different ways of meeting the needs of older persons.

Second, through resource and program development, area agencies on aging provide technical assistance, public promotion and support and training to existing service programs and initiate new programs or agencies through technical assistance for grant writing, program design and implementation. For example, in 1983, my area agency on aging in east central Illinois designated and contracted with eight local organizations to provide case management services to older persons, in joint contracting arrangements with the Illinois Department on Aging.

Third, through the management of grants and contracts and coordination activities, area agencies on aging purchased a variety of preventive and long-term care services which complement those provided under the State of Illinois' Community Care Program. For example, in fiscal 1983, with Older Americans Act funds received through the Illinois Department on Aging, area agencies on aging in Illinois purchased over 61,000 hours of home health services for 4,175 older persons; over 40,000 hours of homemaker services for 1,000 persons; over 360,000 of chore services for 8,100 persons; over 54,000 friendly visits to 5,182 persons; over 154,000 telephone reassurance calls to 3,700 persons; and over 1,800,000 home delivered meals to over 18,000 persons.

Area agencies also purchase congregate nutrition services and health screening services which promote health and prevent disease. In east central Illinois alone with Older Americans Act funds our area agency on aging serves over 400,000 meals at 68 nutrition sites to over 8,000 older persons annually. Our area agency on aging also purchases flu vaccine which is administered to almost 12,000 older persons every year.

Through grant management and regular program monitoring and evaluation activities, the area agencies on aging foster the coordination of services through several funding sources. Case coordination units, for example, have established working agreements with service providers to facilitate the referral of older persons for services. We also assist the Illinois Department on Aging in monitoring the services provided by vendors of the State's Community Care Program and helping to resolve problems.

The fourth role of area agencies is to assist older persons in obtaining services by:

Purchasing local information and referral and outreach services which may prescreen applicants for long-term care services and assist persons found ineligible for the community care program,

Providing information and referral services directly and training local I&R staff and volunteers; and

Purchasing and administering case management services including pre-nursing home admission screening which assesses older persons and links them with less expensive care in the least restrictive setting.

In fiscal year 1984, out of a total of $31.2 million title III funds, area agencies on aging will purchase $3.7 million for case management, $2.1 million for I&R and $1.1 million for outreach. In addition, they plan to spend $1.5 million of Illinois general revenue funds for case management services. Together, these services form a system at the local level which informs individuals and older persons and their families about preventive and community-based

long-term care services and assists them in selecting those services most appropriate to meet their needs.

I hope this information has helped to illustrate the scope of area agency on aging responsibility and our role in development and delivery and delivery of services. We expect that the demand for home health and other community based long-term care services will steadly increase as the vulnerable aging population increases and as the new medicare cost containment measures force early hospital discharges. This increase in service demand will place a heavier demand upon scarce title III-B funds unless significant changes are made in the structure of the medicare and medicaid programs.

As an association, we advocate for the reauthorization of the Older Americans Act through fiscal year 1987. We advocate for amendatory language which emphasizes the role of area agencies on aging in developing a continuum of care which is the coordination and integration of wide range services to meet the changing needs of the diverse aging population.

Here are two issues of concern: First, the issue of first right of refusal. We feel that it is too open-ended. We would like to see, at a minimum, an amendment which speaks to the current process of de-designation. The other issue is the mandate of services by area agencies under elder abuse. We are indeed asking for title III funds which are already stretched, to be stretched even further. We recommend that Congress increase appropriations levels for title III-B to meet the growing demand for health supportive services and AAA mandates authorized under the Older Americans Act.

We also recommend that they look carefully at title IV which establishes with State and area agencies training capabilities of their staff.

Thank you very much.

Senator PERCY. Thank you very much.

Now, Jean Rogers, we're happy to have you testify. Jean.

STATEMENT OF C. JEAN ROGERS, PH.D., SPRINGFIELD, IL, MANAGER, DIVISION OF LONG-TERM CARE, ILLINOIS DEPARTMENT OF AGING

Dr. ROGERS. Thank you, Senator Percy, and thank you, also, for the opportunity to testify about home and community based long-term service.

I'm Dr. Jean Rogers, and I manage the Community Care Program for the State of Illinois. I would like to tell you a little bit about this program and what I see in the future for home health care.

The Community Care Program is a statewide program of community services which are designed to prevent or delay inappropriate institutionalization. This year, we are serving over 15,000 older persons a month. We provide chore services, meal preparation, shopping and transportation to medical services, laundry, and some assistance with bathing, dressing, and grooming. Without these services, many of our clients would have to go to nursing homes.

About 35 percent of the persons we serve are medicaid clients and the State receives Federal reimbursement for their services as

a result of a medicaid waiver which was awarded to Illinois in June 1983. As part of that waiver we prescreen every nursing home applicant who will need public assistance with 60 days of admission to the nursing home. If home care is an appropriate alternative, we offer applicants the choice of home care or nursing home care. If they choose home care, local case management agencies arrange and monitor services.

This program, while new, has been very effective. We screen over 900 nursing home applicants each month and divert about 130 of these applicants to home care. The average cost of home care is $195 a month, which is much less than the cost of group care, and we have begun to see a decline in the State payment to group care facilities. We estimate that over 500,000 patient days of group care will be saved next year as a result of these efforts.

In addition, we have seen a 24-percent reduction in nursing home admission, compared to last year. There are several features of the Community Care Program in Illinois which are different from programs in other States. Community Care is operated on an entitlement basis. Any older person with a demonstrated need for long-care and with assets less than $10,000, an amount which would be expended in less than 1 year if placed in group care, is eligible for Community Care services. Without an entitlement program, we found that waiting lists formed and we were unable to serve the person who was in imminent risk of placement.

There is no income ceiling for services. Instead, clients are asked to share in the cost of their care. Persons below a protected income level, SSI plus an add-on for average medical expenses, pay no fee. Above this income level the fee increases with increasing income and increasing cost of care. The average fee for those who must pay a fee is about $25 per month. We have found the fee schedule to be an effective deterrent to overprescription of services and discourages the higher income person. The average income level of our case load is around $450 a month and we have very few persons whose income exceeds $750 per month.

In terms of the future, I foresee a continued growth in home care services since we have been able to demonstrate the growth occurs at the expense of group care placement, and is a cost effective alternative. We are able to serve four or five persons in home care at the cost of one person in group care.

I also foresee an increasing range of home services, since we are in a position to fund whichever services are needed, as long as the total cost of care does not exceed an established maximum—the cost of group care for the individual. Services which are likely to be included include respite, home health, sitter/companion, and some housing assistance.

I anticipate that cost sharing will continue in Illinois and that other States will adopt similar mechanisms for persons above a protected level. I believe that Illinois' approach is superior to spend-down, which is the current medicaid practice. Spend-down does not provide any incentive to the client to reduce service costs.

Finally, I would hope to see an integration of medicare benefits with home care services offered by States under medicaid, Older Americans Act funds, and State funds. We are well aware that medicare is designed to assist with the cost of acute health care.

However, in older persons, acute care needs are inextricably interwoven with long-term care needs.

At present, providers of service arrange and deliver medicare services until the benefits are exhausted. Then they turn the client over to our Community Care Program for services. We believe an up-front coordination of services would produce no increase in expenditures and might even reduce total costs—particularly if the medicare services were part of our maximum service cap.

However, this coordination would require substantial changes in medicare. Two key changes in Illinois would be to cap medicare home services in conjunction with other home services, at the cost of comparable group care and to require the involvement of the local case management agency in the authorization of medicare home services.

To summarize, Illinois has demonstrated that home services can be a cost-effective alternative to group care for some older persons. We have a program that is diverting older persons from group care and is meeting the needs of thousands of Illinoisans. We would be pleased to work with you as we continue to refine and improve the program.

Thank you.

Senator PERCY. We thank you very much.

Just a few questions, which I think can be answered briefly.

There is talk, Ms. Pinkerton, of using area agencies as case managers for both medical and social services.

Do you feel that area agencies are prepared to make medical choices about what services people need, and should receive?

Ms. PINKERTON. Perhaps I need to preface my response by telling you, Senator, that the area agencies here in Illinois were the case managers some years ago for the Community Care Program. We felt that it was quite effective. We did have a professional staff of social workers and people with medical backgrounds, and some agencies had registered nurses on staff doing their assessment. We felt that it was quite effective because it used central management to cut administrative costs. We felt it was a way to provide for continuity training and a staff that had a similar competency level.

The State of Illinois chose to give those contracts to the CCD vendors and has since moved to individual contracts, known as the case coordination group, which you have heard about today.

My response would be from my area's experience. I think that we can do so. I think that the models that are now in existence throughout the Nation, including Michigan and Maine, are working quite effectively. I don't feel that's a direct service. I feel it's a very appropriate role for area agencies as planners and coordinators, to be the gatekeepers.

Senator PERCY. I think you've covered that pretty well. Everybody agrees it's a challenge to assure quality of care with home and community-based services. You as coordinator of various agencies might be in an ideal position to adjust some safeguards or quality service to clients. Tell us, how do you ensure that quality service is provided?

What training requirement do you have for providers who receive AAA funding?

Ms. PINKERTON. We do as you know, have a mandated role to both monitor and evaluate programs. We take this very seriously. We have standardized forms that we utilize to both monitor programs to evaluate their performance, to evaluate the quality of care that clients are receiving on a regular basis. We do carry out some client reviews also. We have an ongoing responsibility not only to work with service projects in a monitoring role, but also to provide them with training opportunities. We provide that opportunity on an annual basis and each month. For example, in our agency, we have some type of minitraining program, whether it's dealing with medicare or whether it's dealing with consumer fraud. We have a staff person to provide the coordination for the training.

We also have regular meetings bimonthly with our case coordination units, and community care providers. That gives us an opportunity to resolve problems and answer their questions while also providing an ongoing training program. The State of Illinois also provides an annual training conference. We feel the opportunity is there and our providers are taking advantage of it.

Senator PERCY. Thank you very much, indeed.

Dr. Rogers, is the Community Care meeting the home care needs of those clients?

Dr. ROGERS. I think we can show some success, but there's still room for improvement. There is a gap that very clearly identifies that a number of persons are going into nursing homes, mainly because there's a lack of home health care advantage to them. They're not qualified and their medicaid and medicare services are somewhat limited and don't meet their needs, and there is a gap which has been identified.

Senator PERCY. The medicaid waiver under which you're providing many services is effective only for a limited time. I think it's a 3-year program which expires June 30, 1986, but can be renewed.

Is that correct?

Dr. ROGERS. Yes.

Senator PERCY. What do you anticipate in the future for people who have been receiving care under the waiver? Will you be able to serve them?

Dr. ROGERS. It's important to recognize, Senator, that in this State, Community Care Program is for people who exceed the waiver. About a third of our clients are covered under the waiver. If we did not have the waiver, it would be necessary for the people of Illinois to pick up the waiver and I cannot anticipate an unwillingness to——

Senator PERCY. The process you use to help keep costs down creates a situation where clients may be switched from one provider to another, where the cost is lower.

Do you believe the lack of continuum creates a problem?

Dr. ROGERS. Over the last year we essentially see that it does and we are taking several steps to reduce that potential and we still seek cost-effective quality services. We will not act statewide to protest the proposals in order to limit the other areas of the State that might experience that lack of continuity. We'll also not shift providers unless there's a substantial rate cut to the State in the cost area of $25,000.

It makes it difficult to understand this in many instances. The new agency has been able to hire those people that were previously serving the communities. In that instance the client will experience very little service.

Senator PERCY. The people who have been receiving care in the waiver—let me make sure I understand—are you going to be able to continue to help them?

Dr. ROGERS. I don't know. It depends on the State appropriation. If we cannot depend on the State for appropriation——

Senator PERCY. In some cases, Colorado for example, residents of nursing homes have been screened for appropriateness of placement. They are reevaluated to determine whether they really need to be there. If not, in some cases the State may stop paying for their nursing home care.

Is the Community Care Program undertaking this sort of post-admission screening? If so, does your program insure that your clients' choices are respected?

Dr. ROGERS. We maintain or insure that each person's freedom of choice is respected in terms of placement. If the person chooses nursing home care, they are certainly allowed to go there.

However, in this State many individuals have indicated an interest or desire to return to their homes and where case coordination units have found that can be done, services can be arranged to meet that need. It has been accomplished. In fact, our data suggest that around 50 clients will be deinstitutionalized this year.

Senator PERCY. I want to thank you very much, indeed.

Why don't you both just stay here while I make just a few closing comments.

I'd like very much, first of all, to urge that all of you who have not signed a registration sheet at the table near the door to please do so before you leave. If you would like a copy of this hearing when it's printed, I'll see to it that a copy of it is sent to you, if you have written legibly enough so I could read your name and legibly enough so the Postal Department can be notified of your mailing address. If you haven't put a ZIP Code down, it might help if you put a ZIP Code on it, or if you don't think you've given me an adequate address. The best way to communicate with me about this hearing or anything else, any other problems you may have, is just Senator Charles Percy, Old Post Office Building, Springfield, IL. I don't think you need a ZIP Code with that address, though if you had one it would probably help.

I'd like to just ask a few questions of you to get a little feel of your own thoughts today. As I wrote my book, "Growing Old in the Country of the Young," one of the problems I saw 10 years ago among older people was, first, poverty, and second, the fear of poverty. They were concerned that the increased cost of living, inflation, and so forth, would cause them to not have enough to live on. When we consider that one-third of all widows living today are living under poverty, under poverty level, it still is true today.

Let's voice a few of these things. All of those who believe that the fear of poverty is one of the most important problems in the minds of the aging, that is, 65 and older people today, say "aye."

All those who feel it's not any longer a real problem, say "nay."

The "ayes" appear to have it, and the "ayes" have it.

Now, let me ask you the question as to whether or not loneliness is a problem.

Is this a real problem for people who are aging, continuing to age and have possibly been separated from their families because their children have gotten jobs in other areas, and their friends that they knew as they grew up have either passed away or moved away, and they just have a lonely existence?

How many feel that loneliness is still a problem with older people, as I identified 10 years ago and have been doing something about since then?

All those who feel that say "aye."

All those who think it's not, say "nay."

The "ayes" appear to have it and the "ayes" have it.

I would like at this time to take a microphone over to the press table. I have never done this in a public hearing that we've had. However, I think because we touched upon such an extraordinary issue that we need to get more information out to aging Americans, and what their needs and their concerns are.

I wonder if each one of you would mind just identifying yourselves by name and the particular news media that you represent, so that all of you will know where the articles, where the information about this program will be written, so that before you get your copy of the printed hearing, you can have a chance to read about it in local news media.

Mr. AMEED. My name is Safu Ameed, St. Louis Post Dispatch.

Mr. MALOZI. My name is John Malozi. I'm a reporter at the Globe Democrat at St. Louis.

Ms. MOTTAZ. My name is Judi Mottaz. I'm a reporter for the Alton Telegraph.

Mr. COSBY. My name is Jack Cosby. I'm a reporter for the Granite City Journal.

Senator PERCY. While we're passing it down, I just want to thank our friends from the field of journalism for being here. So many times they run out to a fire or run out to a robbery, or a murder or something like that. This is not exactly a sensational situation, but it affects more people in America than any other problem, because if you're not aging, you're dead. If you don't know somebody who's aging, you are not taking care of your aunts, your uncles, your grandmothers and grandfathers, et cetera, et cetera. So it's really a problem that I find affects every single living American including the members of our audience, each of whom probably have aging parents or grandparents.

Mr. SMITH. My name is Sandy Smith, and I am from the Granite City Center Reporter.

Ms. THOMPSON. My name is Cheryl Thompson, and I am the editor of the Granite City Center Reporter.

Senator PERCY. Fine.

Thank you very much, indeed.

Let me just get a few more judgments from you for my information, ideas. I probably visited more nursing homes, more senior citizen retirement centers over the past 18 to 20 years, and I set a call for action when I was defeated for Governor for 2 years. We just served the needs of people, particularly the elderly who needed people and wanted people, and had nowhere to turn. We had the

help of the media in that, and many times we have gone to nursing homes on a Sunday and we're the only visitors that ever come that weekend to see some of these people. It tears our hearts out to see that loneliness, and that's why I wrote to every high school in the State asking them to please adopt a nursing home or retirement home and please go there where you're really needed and wanted, and redevelop a relationship between young people and older people.

They were all adopted as grandchildren and grandparents, and they come in and they have someplace to go and something to do and they feel important. When they visited the senior citizens they had someone to dress up for and someone to look forward to, and they wrote letters and made phone calls, and combed their hair and things like that. And it works very well.

Those of you in the poverty area, 4 or 5 years ago the biggest question was, is my Social Security system going bankrupt. I haven't had that issue raised since the Greenspan Commission studied and revised the system to fund it.

How many people feel that the bankruptcy of the Social Security system is a real problem, and we still haven't solved that problem?

All who think that, say "aye."

All those who feel we have pretty much solved the problem and do not really worry, lie awake nights thinking, is the Social Security system going to go bankrupt, say "nay."

It appears the "ayes" have it, but the "nays"—there is still enough concern out there that we have got to keep working on it. Now we need to keep working strongly on the problems of medicare and medicaid, to make sure that it is properly funded.

A few years ago I got $1,800,000 for a program called the nutritional lunch program. It seemed a shame to me that we had to waste, and throw away, or give away abroad a lot of surplus food. It seemed to me we ought to have a lunch program that brought older people together, let them pay what they could, a dime or a dollar, to come together someplace where they would meet, put their legs under a table, plan trips, play a little pinochle, do something, have someplace to go, see people and so forth.

We're spending now over $400 million on that program that I started with only an experimental program of 13 feeding stations in Illinois. Now we have hundreds of them scattered all over. Through revenue sharing, we've been able to build senior citizen centers and house them in beautiful facilities.

How many of you feel that the investment of almost half a billion dollars is a worthwhile investment and should be continued?

All those who think it's a worthwhile investment, say "aye."

All of those who feel it's a waste of money and not a good investment, and not to be staffed, say "nay."

The "ayes" appear to have it, and the "ayes" do have it.

As I indicated, I started the Meals-on-Wheels program years ago. Most of the people taking the meals around are volunteers. Some of them are paid staff, but most of them are volunteers.

How many feel that program is a worthwhile program, and is cost effective and should be continued?

All those who think it should be continued, say "aye."

All those who feel it's a waste of money and should be discontinued, say "nay."

The "ayes" appear to have it, and the "ayes" have it.

Let me just ask you to do one thing when you leave here. Talk among your fellow citizens, whatever their age, about the discussions we have had here. Point out the newspaper clippings that come out in the local media, and write letters to your local media which you have, and identify those ideas that you didn't have a chance to express. We haven't taken testimony from the floor. If you write a letter to the local news media, or write a letter to me and send a copy to them, they will print it as a letter to the editor, that most media have. And even 60 Minutes is now having it, letters to the editor, and they read them Sunday nights.

Your viewpoints and ideas on this problem are very important, important because you know the problem of this particular seven-county community and you know the problems as they relate to people whose lives you want to touch and improve as a result of those ideas.

So if you could do that, I would really very much appreciate it. I do want to thank each of you for coming. I understand we had people here representing not only the seven counties in this AAA region, but some people from even farther away, and I think that's perfectly wonderful.

And of course, I'd like to thank Senator Baker, Senator Heinz, the chairman of the Senate Committee on Aging, Senator Dole, and Senator Long, who with me last night were in session steadily for 19 hours, and 5 minutes, in order that we could finish up at 5:15 this morning, and let us get to our meetings, and keep our dates. This is one day that I just did not want to miss because each one of you are valuable. You're here because you are dedicated to this work, and I don't know of one more noble thing that you can devote to and for, than the care of those who really need your care, who need your love and attention and to feel important and needed. When they see that we do care enough about them, they will do wonderful, indeed.

So, with that, I want to say again, thank you for all that you have done. I would like, just like the preacher at the church, to stand in back of the room and as you leave by that door, I would like to shake hands with each one of you. I also have at least two people who have asked to see me, and then I must get on my way.

Since I don't have a gavel to adjourn this meeting, I'll do it with my fist.

This meeting is adjourned.

[Whereupon, at 11:55 a.m., the hearing was adjourned.]

APPENDIX

MATERIAL RELATED TO HEARING

ITEM 1. LETTER FROM ARLENE CROUTHER, R.N., B.S., M.A., EXECUTIVE DIRECTOR, VISITING NURSES ASSOCIATION, FAIRVIEW, IL, TO SENATOR CHARLES H. PERCY, DATED APRIL 12, 1984

DEAR SENATOR PERCY: Our Visiting Nurses Association has been in existence since 1918. The home health field has been in the business of providing home health care since its inception on a part time and intermittent basis.

I, Arlene Crouther would like to offer testimony on the part of beneficiaries for those seniors affected by Federal health delivery systems and also as an administrator of a home health agency.

This testimony is given as information regarding the deplorable conditions the elderly are experiencing in our society.

In 1980, Illinois Department of Public Aid began to cut the professional service of the VNA, stating R.N. service ordered by the physician was not necessary and approving in part other service. Uncovered service was billed to United Way. The VNA, not anticipating these problems for 1980, over-extended itself and United Way monies were not adequate for coverage. Over $27,000 was met in spend down alone at that time.

Conditions for the elderly have deteriorated. November 1, 1981, all medical assistance cases were issued spend-down envelops, which were for a 6-month period. A medical assistance recipient to obtain prescriptions, medical care or home care must spend down to $238/month before receiving the green card. For example: If a patient receives $350/month social security, the individual must have $672 in medical expenses paid within a 6-month period before receiving a green card. This means the patient is not buying necessary medication, visiting the physician, or having needed lab work, or X-rays due to inability to pay for the services.

The economic crisis affecting our seniors with limited medical coverage under medicare is very serious. The elderly, under the medicare program, must pay an exorbitant amount for visits to the physician. Laboratory and X-rays are expensive and physicians frequently request blood levels be monitored, reimbursement is extremely inadequate. If a physician charges the patient $35, the patient may be reimbursed at 80 percent of $10 to $12 per visit.

MEDICARE CERTIFIED ACTIVE AND PARTICIPATING HOME HEALTH AGENCIES, DEC. 30, 1978 TO APR. 28, 1983

Type	1978	1979	1980	1981	1982	1983
VNA	494	510	504	514	517	519
Combination	48	50	63	55	59	58
Official	1,278	1,281	1,255	1,234	1,211	1,227
Rehab-based	7	6	9	11	16	19
Hospital-based	319	349	377	432	507	566
SNF-based	8	11	10	10	32	129
Proprietary	146	165	205	287	628	965
Private nonprofit	394	443	509	547	632	674
Other	48	49	35	38	37	32
Total	2,742	2,864	2,967	3,128	3,639	4,202

The patient who has paid social security and receives $263/month must expend $180 in a 6-month period before being considered for the green card, while the individual on SSI receiving $263/month does not have to expend $180; these individuals are automatically covered by IDPA whereas the patient who has paid into social security is penalized.

There are so many case examples of severe problems and situations in which patients will certainly require costly nursing home placement if situations are not remedied.

Housekeeping, chore service under the community care program are insignificant helps for the elderly if they have no money to buy medication to sustain life or be monitored by physicians or have physical needs met.

The individuals on medical assistance are the very one confined to their home due to debilitating and deterioration conditions. Many of these patients are asphasic, amputees, CVA/c paralysis that live in the most impoverished situations.

Home health agencies have increased from 2,742 in 1978 to 4,202 in 1982. A significant growth has been the proprietary type agency which grew from 148 agencies in 1978 to 965 agencies in 1983, after approval from payment under the medicare program.

Proprietary agencies have flooded the market. Hospitals are limited by DRG's. However, profitmaking organizations are charging $50 to $60 per visit, not paying social security or benefits on staff, making visits as long as medicare covers, driving up the cost of home care, because they are interested in making a profit. Then our senior citizens are told the cost of medicare has increased, their insurance premiums will be increased to meet the need. Yet, we have given no increased benefits or coverage under the medicare and medicaid programs. The seniors continue to pay for medications if they can afford them. Frequently, seniors omit seeing the physican because financially they cannot afford the cost. Proprietary agencies continue to skim the cream off the top and then discontinue service when patients are unable to pay.

Research regarding medicare certified home health agency growth demonstrate the following patterns:

(1) In the past 5 years (1977–82), there has been an annual increase of 8.5 percent in the number of medicare certified agencies. Over the last 3 years (1979–83), average annual increase has been 94 percent.

(2) Largest growth in proprietary, institutionally based, and private nonprofit. Between 1980 and 1982, there was a 241 percent increase in the number of medicare certified proprietary home health agencies, 58.5 percent in the number of institutionally-based (hospital, SNF's and rehab facilities.

There has been a continuing flood of data on the growth of home health care in recent years to stem the escalating cost of health care, which rose by 15.1 percent nationally in 1981.

Total medicare reimbursement for home health rose from $443 million in 1978 to an estimated $1.2 billion in 1982.

My question is: "Are these cost legitimate?" Why are we allowing the profit making sector to escalate costs, collect for covered services, and then discontinue care because medicare would no longer pay. President Reagan indicated society must look to the voluntary sector for help. Through the years the United Way has been assisting with the needs of the poor elderly who could not afford to pay for service.

In October of 1969, medicare had to cut back on payment due to cost and custodial services were omitted. United Way came to the front. Today, voluntary not for profit home health agencies continue to provide service, continue to follow regulations, continue to screen clients and utilize other resources in meeting the needs of uncovered service. We have continued over the years to keep costs relatively low. Our agency reimbursement under medicare is $25.01.

Proprietary agencies are allowed to enter the market, drive up the cost of home care, not pay social security or benefits, pay personnel on call basis, therefore giving the home health care industry a bad name. If medicare in 1969, recognized it could not pay for custodial needs, how can the system at this time allow profit off a program that is financially in trouble?

We continue to plague the elderly with the cutback in needed hospital care, noncoverage of medication, noncovered service, physician fees and lab costs, raising the cost of their health insurance. What have we really given them?

The elderly of our community are being confused with duplication of service. While the elderly should be benefiting from expanded home health, seniors are

being burdened with increase cost, with no additional benefits in their own personal life.

Respectfully submitted,

ARLENE CROUTHER, R.N., B.S., M.A.

ITEM 2. STATEMENT OF RUTH MELTON, HIGHLAND, IL, REGIONAL CHAIRPERSON, ILLINOIS COUNCIL OF HOME HEALTH SERVICES

We thank you for giving for giving us the opportunity to present concerns first-hand. We welcome you to Southern Illinois.

As of March 1984, there were a total of 205 agencies with 53 branches serving the citizens of Illinois. There are 21 more that will soon be surveyed for participation in the medicare program as home health agencies, with the potential of 4 more branch agencies.

In Illinois, the Illinois Department of Public Health has the responsibility for doing the surveys for home health agencies. Staff shortages and escalating volume of agencies have caused a backlog of scheduled surveys. We providers would like to see the certification visits maintained and the scrutiny of staff recordkeeping, policies, and the like continue, but we feel that it would be a more workable system to have the agencies certified for a 2-year period instead of yearly. More frequent site visits could be made if there were major program changes. This would continue to insure quality of services and should prove to be a more workable system for the survey team and the provider.

We would like to alert you, Senator Percy and your staff, to the problems that we as providers see with different intermediaries having different interpretations of the medicare regulations for home health. At our professional meetings, speakers representing HCFA admit to us that we have the toughest regulations and use the least amount of medicare dollars. To add insult to injury, we find our fellow agencies, in neighboring States or an agency in our own State dealing with office of direct reimbursement or some other intermediary not having to comply with the same rules given to the greater majority of the providers of home health in Illinois. We are accused of not keeping costs down, yet it takes people to produce the paperwork demanded by Blue Cross of Chicago. If we were a St. Louis agency, dealing with Missouri Blue Cross, we could make 12 or less visits to a client per month and not have to send a written summary. The physician's order would be adequate. If we make even one visit to a client, we must fill out a one-page summary form which, along with the M.D. order must accompany the bill.

We are told that this is to curb fraud and abuse. It may be doing that, but the facts haven't come back to us as providers. Are there a greater percentage of fraudulent agencies in Missouri? Has Illinois got the best providers track record in the country? I think not. We, the providers can't afford to have one fraudulent provider among us. We rely heavily on our reputations as providers of quality services. One newspaper article about a home health provider accused of deceptive practice injures us all. We can't afford this kind of advertisement. Let HCFA consider unannounced vists and spot checks to compare records to billing.

Every provider attending today's hearing takes utmost pride in what he or she is doing to help the American public. The most distasteful part of the job is having professionals take valuable time to summarize what they have already done. Care procedures and treatment that was provided at the order of the attending physician for a patient who is too homebound to avail themselves of the services elsewhere. The agency suffers if you hire a nurse for his or her nursing not writing abilities. I've heard that some agencies even hire professional writers. Surely the intermediary can be more flexible in this State. We believe the best answer would be to get all intermediaries to prove that they interpret the Federal Rules the same from State to State and from town to town. Illinois providers can only get so much pride out of knowing that we deal with one of the toughest intermediaries in the country.

Another area of concern is that we have heard that the GAO is thinking of implementing an idea that they have been tossing around for at least 3 years. That being the voucher system. I believe that the Senator needs to question this mode of cost savings. With the voucher, the individual would purchase medical insurance in lieu of medicare. I assure you that presently one of the major concerns for the senior citizen is how to choose which type of supplemental insurance would be best for them. We have found that so many are not armed with the type of plan that they thought they had purchased.

Their concerns are the acceptability of the plan, the type of coverage, will the hospitals and physicians accept it? What is the insurance company's view of preexisting

conditions? Will the claim be disallowed, etc. These are major considerations and most insurance plans are being sold by someone with a lot of "sales know-how". Seniors could be persuaded into taking a policy which does not meet their needs.

In conclusion, thank you for the opportunity of making a presentation at today's hearing. We would encourage more frequent opportunities to exchange ideas on the needs of the aging population and other concerns to the American public.

ITEM 3. STATEMENT OF ANN ELLIS, ASSISTANT COORDINATOR, HOME HEALTH CARE AND HOSPICE, ST. ANTHONY'S HOSPITAL, ALTON, IL

"Megatrends," written by John Naisbitt, alludes to the trend that the more technical hospitals become, the less people are being born there, dying there, and avoiding them in between. Many technical advances have been made in the health field which has improved the quantity of life and in most cases, the quality. With this technology, comes increase in cost and eventually tightening of regulations to control costs thus DRG's. It is said that history repeats itself. Just as people used to be cared for in the home from birth to death, today home care and hospice care is becoming increasingly popular because of the humanistic, holistic, and cost effective approach of care being achieved by an interdisciplinary team which can be high touch and high tech care in the home versus in an institution, where the environment is often dehumanizing, specialized, and cost prohibitive.

The humanistic care approach may eventually be the most important ingredient of home health and hospice care where the basic human needs can be more readily identified. Empathy, skilled, patient-centered care can be delivered in the patient's environment. This is an invaluable service. Untold psychological damage can be done when a person is removed from his environment into a strange environment with unfamiliar caretakers and loss of control. There is no place like home whether home is a shack or a castle. Humanistic care stresses quality of life based on individual needs of the whole person.

Holistic care is the second important factor causing an increase of popularity for home health care. Under the direction of a physician, care is given based on a thorough need and health assessment performed on the initial visit. Professional expertise of the HHC team develops and individualistic, holistic plan of care. All necessary community resources are tapped for the benefit of the patient and family. Often in an institution a patient is referred to as a room number and only immediate needs are addressed. All resources and means are tapped to provide service in the home in order to avoid institutionalization, which is more costly.

Home health and hospice care versus institutional care is definitely cost effective. The average hospital stay in this area is $160 per day not including any pharmaceutical or ancillary services. The average nursing home cost range is between $1,200 and $1,500 per month. A few years ago, a columnist stated that all services provided by home health care could be quadrupled and still be less expensive than a day in the hospital. Today, the figure may be closer to tripled. In home care, families are taught and incorporated in the patient's care and volunteers are utilized.

Some examples of cost effectiveness of home health care versus institutionalization are:

(1) A patient with a pseudomonas infection with treatment of choice being antibiotic injection 12 hours times 10 days. If hospitalized for 10 days the cost would have been $2,000. Home care could have provided this same treatment for $800 if HCFA would have allowed for intermittent care. (Please be aware of Heinz-Bentsen bill, S. 2338, Home Care Protection Act.)

(2) A patient required a chest X-ray: This was done at home using portable X-ray for the cost of $120 versus ambulance fee being $128 plus X-ray of $58.

(3) Many hospitalizations are avoided by close monitoring and reporting of symptoms to physician and in carrying out the prescribed therapy or medical intervention in the home.

(4) Many hospital stays can be shortened and care continued in the home by all therapies, nursing, and supportive personnel. The patent is more content in his own environment and studies have shown that progress is more quickly noted in the home.

(5) A definite trend toward more technical care in the home is being noted. These procedures performed in the home will also help reduce cost. Such procedures as giving chemotherapy, changing tracheotomy tubes, monitoring patients on ventilators, changing gastrostomy tubes and (duo tubes), drawing lab work and taking EKG's and X-ray readings are definitely technical skills that can be performed with TLC (tender loving care) in the home.

Since emphasis is on cost containment in health care while maintaining the quality, isn't it advantageous that home health care and hospice care are available and gaining in popularity?

ITEM 4. STATEMENT OF MARGE HILLEN, HARDIN, IL, ADMINISTRATOR, CALHOUN COUNTY, IL, HEALTH DEPARTMENT

I have been an administrator for 17 years of a home health agency that was established as the results of medicare. Our staff includes three full-time R.N.'s, one part-time R.N., six part-time home health aides, and two full-time clerical staff. We have had in the past, a physical therapist by contract.

In the past year, fiscal year 1983, we served 139 clients for a total of 1,954 home health agency visits. Our agency serves the total county, with a population of 8,675. The area served is very remote, with two certified family practitioners, and has no hospital. Approximately 80 percent of the population lives outside the small villages, making the cost per visit unusually high.

Most of the clients live alone and are 75 years of age or older. These clients depend on our services because of the lack of transportation.

In the past fiscal year, our agency lost its wavier because of intermittent care, due to the intermediaries interpretation of intermittent.

The following is a case of a denial due to interpretation:

Services began on this 72-year-old white female on May 12, 1983, with the physician's orders reading, "visit patient daily", and to cleanse open wound of right lower leg with 0.1 percent acetic acid and apply dressing and observe for signs of infection. This open wound was the result of a deep infected thrombophlebitis after having right knee replacement surgery. She was seen daily from May 12 through June 30, 1983. A family member from out of town was taught to do this on weekends, when they were able to see the patient. This wound was quite extensive, approximately 2 inches long, 1 inch wide, and one-half to 1 inch deep. Was very slow healing and did need daily attention and care.

Visits were decreased to every 2 days starting July 1, as the size of the wound was beginning to become smaller, 1½ inches long and one-half inch wide, but had developed a canal in the upper end that was approximately 1½ inches deep with purulent drainage. There were 15 visits during this month.

Beginning August 1, 1983, the doctor again ordered daily visits for 3 weeks, for R.N. to cleanse out wound and insert NuGauze pack into deep canal. Size of wound was now 2 cm. opening and 1¼ inches deep. There were 23 visits in August. She was readmitted to the hospital on August 30, 1983 for surgical repair of this wound.

Our home health agency was denied 34 visits from May 12, 1983 through June 30, 1983. A more realistic approach would be the cost per home visit versus hospital costs.

Example: 34 denied agency home visits at $29 per visit equals $986, versus 34 hospital room charges at $150 per day, which equals $5,100.

By keeping the client in her home environment and offering skilled nursing care, the financial savings totaled $4,114.

As an administrator, the realistic client skilled care and financial approach would be to keep the client in her own home environment.

ITEM 5. STATEMENT OF NOLA KRAMER, R.N., JERSEYVILLE, IL, ADMINISTRATOR, JERSEY COUNTY, IL, HEALTH DEPARTMENT

I am an administrator of a home health agency, employed by a home health agency for 17 years. The home health agency was established as a result of the medicare program. The agency employs three full time nurses, one part-time nurse, plus eitht part-time home health aides. Physical, occupational, and speech therapy is provided under contract.

During the past year, we provided services to 141 clients for a total of 8,095 visits. We serve the entire county which has a population of 20,500. The area is rural with approximately 50 percent of the clients living outside heavily populated areas, which increases the cost of providing care.

A large percent of our home health clients live alone and are 75 years of age or greater. Most of our clients have multiple diagnoses and are taking on the average of eight to ten oral medications.

INTERMITTENT CARE

In the past fiscal year, my agency lost its waiver for two periods due to the intermediaries interpretation of intermittent care. Following is a case example of the restrictive definition as interpreted by the fiscal intermediary.

A 85-year-old woman who received home care for daily dressings of a skin graft on her lower right leg. Due to the location of the wound and the need for professional observation and knowledge of sterile technique, the physician ordered daily dressing changes. Daily care was needed, but since this patient did not meet the intermediary's interpretation of "intermittent" care, medicare reimbursement was denied from the day of admission. This determination was received August 25, 1983 for the period June 1, 1983 through June 30, 1983.

Daily home visits for the month of June 1983 cost $1,471.45 versus the cost of institutional care at $4,200.

WAIVER OF LIABILITY

I feel that small home health agencies such as ours is discriminated against because of the 2.5 percent denial rate. It is becoming extremely difficult to attempt to meet the client's needs in a small agency when a very few denied claims can result in the agency loosing its waiver, which means a great loss of funds. It is my opinion that this low denial rate is favorable for large agencies but could prove disastrous for small agencies such as mine.

I beg you to consider the valuable services small agencies provide to the citizens of this country.

ITEM 6. STATEMENT OF RAYMOND UPHOFF, COORDINATOR, NURSING HOME VISITORS PROGRAM, BELLEVILLE, IL

My name is Raymond Uphoff, I reside in Belleville, Ill. I am coordinator of the Belleville Area College Nursing Home Visitors Program. The program operates out of Belleville area College's Programs and Services for Older Persons (PSOP) Senior Center at 201 North Church Street, Belleville, Ill. The program was formed in 1980 and since February 1981 our volunteers have been making regular friendly visits to residents in several of our Belleville area nursing homes, of which we have 10.

The volunteers furnish me with a report on all residents they visit which enables me to promptly handle any matters needing correction with the home's administrators. The residents appreciate the visits from our volunteers and our service is very helpful.

As coordinator, I make frequent visits with my volunteers. I have come to the conclusion that from my observations there are an increasing number of residents in the homes who should not and need not be there. These are people who are ambulatory and appear to be in fairly good health. They are people who with a little outside help could remain living in their own homes. Yet they occupy a room in the nursing home at a rate they cannot afford to pay until their resources are exhausted and they are forced to go on public aid.

It is my considered opinion that one way your committee and Congress could cut down on the exorbitant cost of caring for our elderly is to fund those programs which provide for services within their own homes. One such program is the senior companion program (SCP).

Belleville Area College's Programs and Services for Older Persons has a senior companion program and the demand for companions far exceeds the number of companions the program is funded for.

In conclusion, I urge your committee to investigate all possible avenues to keep the elderly in their own homes and recommend to Congress the proper funding of the senior companion program and similar programs.

Thank you for considering my point of view.

ITEM 7. STATEMENT OF EUGENE VERDU, DIRECTOR, BELLEVILLE AREA COLLEGE PROGRAMS AND SERVICES FOR OLDER PERSONS, BELLEVILLE, IL

The senior companion program (one of the programs under Programs and Services for Older Persons) trains and places persons 60 years of age and older, and who meet the required income guidelines, in homes of persons who are elderly and homebound, or whose family needs respite care. The companions are given a stipend of $2 an hour and work 20 hours per week. Each Companion is paid $2,088 a year.

The majority of funds for the program are provided by ACTION, a Federal volunteer agency. Nationwide, there are only 60 senior companion programs. With these types of programs, provisions are made for those needing minimal support in order to remain in their homes, thereby saving the Government a great deal of money by keeping the people from being institutionalized.

Congress should ensure that changes are made within the guidelines to enable the programs to become more effective. For example, local match is unrealistically high, considering the fact that according to ACTION guidelines, the people being served may not donate towards the support of the program. In addition, requirements state that only 10 percent of the total budget may be alloted for administration. Since we receive such small amount for our grant, it is almost impossible to meet this requirement.

In all of Southern Illinois, there are only funds available for 60 senior companions. These 60 companions serve approximately 115 clients, enabling them to stay in their homes.

Thank you for allowing me to submit this testimony regarding the senior companion program.